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Sheffield Health and Wellbeing Board

Sheffield City Council • Sheffield Clinical Commissioning Group

Thursday 29 September 2022 at 2.00 pm

Town Hall, Sheffield City Council

The Press and Public are Welcome to Attend

Membership

Councillor Angela Argenzio	
Dr David Black	Sheffield Teaching Hospitals NHS FT
Sandie Buchan	Sheffield CCG
Alexis Chappell	
Greg Fell	Director of Public Health, Sheffield City Council
Dr Terry Hudsen	NHS Sheffield CCG
Councillor Douglas Johnson	
Kate Josephs	
Benn Kemp	South Yorkshire Police
John Macilwraith	
Sharon Mays	Sheffield Health & Social Care NHS Foundation Trust
Dr Zak McMurray	Clinical Director, Clinical Commissioning Group
Prof Chris Newman	University of Sheffield
Joe Rennie	Sheffield Hallam University
Kathryn Robertshaw	Sheffield Health and Care Partnership
Judy Robinson	Chair, Healthwatch Sheffield
Councillor Mick Rooney	
Helen Sims	Voluntary Action Sheffield
Lesley Smith	
David Warwicker	

Sheffield City Council

SHEFFIELD'S HEALTH AND WELLBEING BOARD

Sheffield City Council ● Sheffield Clinical Commissioning Group

Sheffield's Health and Wellbeing Board started to meet in shadow form in January 2012 and became a statutory group in April 2013. The Health and Social Care Act 2012 states that every local authority needs a Health and Wellbeing Board. It is a group of local GPs, local councillors, a representative of Sheffield citizens, and senior managers in the NHS and the local authority, all of whom seek to make local government and local health services better for local people. Its terms of reference sets out how it will operate.

Sheffield's Health and Wellbeing Board has a formal public meeting every three months as well as a range of public events held at least once a quarter.

Sheffield's Health and Wellbeing Board has a website which tells you more about what we do. http://www.sheffield.gov.uk/home/public-health/health-wellbeing-board

PUBLIC ACCESS TO THE MEETING

A copy of the agenda and reports is available on the Council's website at www.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information. These items are usually marked * on the agenda.

Meetings are normally open to the public but sometimes the Board may have to discuss an item in private. If this happens, you will be asked to leave. Any private items are normally left until last. If you would like to attend the meeting please report to the First Point Reception desk where you will be directed to the meeting room.

If you require any further information please contact Fiona Martinez on 0114 2734491 or email fiona.martinez@sheffield.gov.uk

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

SHEFFIELD HEALTH AND WELLBEING BOARD AGENDA

Sheffield City Council ● Sheffield Clinical Commissioning Group

29 SEPTEMBER 2022

Order of Business

1.	**Apologies for Absence**	
2.	**Declarations of Interest** Members to declare any interests they have in the business to be considered at the meeting.	(Pages 5 - 8)
3.	**Public Questions** To receive any questions from members of the public.	
4.	**Healthwatch Update**	Verbal Update
5.	**Race Equality Commission**	To Follow
6.	**Learning from Community Engagement during the COVID-19 Pandemic** Report of the Director of Public Health, SCC	(Pages 9 - 64)
7.	**Compassionate City** Report of the Director of Public Health, SCC	(Pages 65 - 76)
8.	**Housing and Health Conference Report** Report of the Director of Public Health, SCC	(Pages 77 - 102)
9.	**Board Review and Terms of Reference Update** Report of the Director of Public Health, SCC	(Pages 103 - 118)
10.	**Joint Health & Wellbeing Strategy Review** Report of the Director of Public Health, SCC	(Pages 119 - 176)
11.	**Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment** Presentation of Dr Chris Gibbons, Public Health Principal, Office of the Director of Public Health	Presentation
12.	**Integrated Care System Update** Joint Report of the Executive Place Director for Sheffield, NHS South Yorkshire ICB and Director of Public Health, SCC	(Pages 177 - 192)
13.	**Better Care Fund Update**	Verbal Update

14. Forward Plan (Pages 193 - 194)

Report of the Director of Public Health, SCC

15. Minutes of the Previous Meeting To Follow

16. Date and Time of Next Meeting

The next meeting is on Thursday 8th December 2022 at 9.30am, at the Town Hall Sheffield

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health, SCC
Date:	29th September 2022
Subject:	Learning from community engagement during the COVID-19 pandemic
Author of Report:	Sarah Hepworth – Health Improvement Principal, SCC Colin Havard – Community Development Coordinator, SCC Shahida Siddique – Chief Executive, Faithstar Gulnaz Hussain – Chief Executive, Fir Vale Community Hub Laura White – Strategy & Partnerships Manager, SCC Dan Spicer – Policy & Improvement Officer, SCC

Summary:

This paper summarises for the Board three areas of work conducted during the pandemic with a focus on engagement with BAME communities:

- The BAME Public Health Group;
- Community Champions; and
- Work on vaccine hesitancy in BAME communities, which built on the engagement approaches developed in the first two.

It then sets out a number of key points of learning for the Board from these, and asks them to consider the value of this work and how to ensure it can be sustainable for the future of Sheffield.

Questions for the Health and Wellbeing Board:

- Do the Board agree that the work described in the report is valuable, and should be maintained as Sheffield emerges from the pandemic and business as usual returns?
- How could this be resourced, and could the previous commitment to recruiting an Engagement Coordinator be revisited with this in mind?
- Do the Board agree that the lessons from the work described in this report provide the building blocks for an approach to engagement that can be applied more broadly?
- Do the Board want to explore this as part of a broader conversation about how we engage with, represent and build trust with communities across Sheffield?
- Do the Board want to take a joined-up approach to this by working with other partnerships and/or linking with best practice within our individual institutions?
- Do the Board want to explore options for how we could seek to build best practice through collaboration with funding and research bodies?

Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board are recommended to:

- Agree that trusting relationships based on open engagement are a critical aspect of good public service delivery
- Note the impact and value of the engagement approaches developed through COVID, and agree that this should be sustained and developed for the future, with capacity identified to do this
- Sponsor a joint workshop with Sheffield City Partnership Board, and other partnerships that may be interested, to consider concrete next steps to learn from this and other work to improve engagement between public services and citizens in Sheffield
- Revisit the previously agreed commitment to recruiting an Engagement Coordinator, considering whether this could apply across partnerships in light of the outcome of that workshop
- Sponsor the development of a proposition to put to potential funding partners to consider the links between effective engagement and health inequalities

Background Papers:

- Engagement and Health & Wellbeing - 28th October 2021
- Health and Wellbeing Board: Future Engagement - June 24th 2021
- Appendix 1: Impacts of Covid19 on Black Asian and Ethnic Minorities the Sheffield Response
- Appendix 2: Community Champions April - August 2022 report

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

This issue relates to health inequalities in general, and so supports delivery against all ambitions in the Strategy.

Who has contributed to this paper?

N/A

LEARNING FROM COMMUNITY ENGAGEMENT DURING THE COVID-19 PANDEMIC

1.0 SUMMARY

1.1 This paper summarises for the Board three areas of work conducted during the pandemic with a focus on engagement with BAME communities:

- The BAME Public Health Group;
- Community Champions; and
- Work on vaccine hesitancy in BAME communities, which built on the engagement approaches developed in the first two.

1.2 It then sets out a number of key points of learning for the Board from these, and asks them to consider the value of this work and how to ensure it can be sustainable for the future of Sheffield.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 Health inequalities are not just geographically spread: they also exist between different ethnicities. A key factor in this is differential access to services, which in turn is impacted by levels of trust; how well services understand communities and how to make their offer accessible and appropriate; and whether people see themselves represented in services and the organisations that deliver them. This paper sets out how good community engagement is a central aspect of addressing these issues.

3.0 INTRODUCTION AND BACKGROUND

3.1 The Health and Wellbeing Board has a responsibility to engage with the public in the development and implementation of its strategy to improve the health and wellbeing of the citizens of Sheffield. During 2021, the Board held a series of discussions on how better engagement can support its aims, concluding with agreement to establish a post to coordinate and support engagement on the Board's behalf, including developing a three-year plan for engagement around health and wellbeing. Although agreed, resources to fund this post have yet to be identified.

3.2 At the same time, learning from the engagement approaches developed in Sheffield during the COVID-19 pandemic is being actively considered, with a focus on the work done to connect with BAME communities and in the context of the Race Equality Commission having recently presented its final report. This work demonstrates clearly the importance of engagement with citizens and communities to building trust and understanding, and in turn the importance of trust and understanding to delivering effective and appropriate public services, and reducing health inequalities. This report sets out some examples of this work, highlights key points for the Board to consider, and asks what approach the Board want to take in response.

3.3 In addition, Sheffield City Partnership are also grappling with similar questions of how best to conduct engagement with citizens and communities, as part of their work to develop a set of City Goals to guide future development. The Partnership are exploring and using some of the mechanisms and structures described below; with this in mind, the Board will also be asked to consider whether there is scope for cross-partnership work focused on engagement, with potential to deliver broad benefits for Sheffield.

4.0 CASE STUDY 1: BAME PUBLIC HEALTH GROUP

4.1 The BAME Public Health Group was established in July 2020, as part of Sheffield's response to early indications that that BAME communities were experiencing disproportionate impacts from COVID-19, a trend that was subsequently reflected and confirmed at the national level through two PHE reports into disparities in risks and outcomes. There was also an acknowledgement among public services in Sheffield that they had insufficient knowledge about the city's BAME communities and faith organisations and how to access them.

4.2 From the start the Group has been co-chaired by SCC Public Health and Faithstar, through Sarah Hepworth and Shahida Siddique respectively. Over 25 BAME organisations have attended, representing African, Caribbean, Somali, Pakistani, Bangladeshi, Chinese, Yemeni, and Roma Slovak communities. It has provided a space for open, honest, and transparent dialogue, exploring some of the factors behind the disproportionate impact of COVID-19 on BAME communities in Sheffield.

4.3 The Group has now spent more than 100 hours collaborating, discussing, reflecting and learning together to explore the impacts of COVID-19 on BAME communities and the reasons for these. Through these discussions, the Group has also explored some of the fundamental issues that have contributed to these impacts. Lack of trust and understanding of national and local governments and public services has been a key theme in these discussions, alongside the impact of austerity and a view that BAME community organisations had been neglected by city decision makers.

4.4 The Group's work since its inception has been hugely impactful, with significant strides made in building trust and understanding between members, addressing longstanding deficits in this area. This does not mean the work has been easy, and a key contributor to success has been strong and committed leadership from the co-Chairs, especially when conversations were difficult or challenging. The work was shortlisted for a national award in 2021.

4.5 A critical feature of the Group's approach was to focus on action as well as discussion and listening. Action was critical in terms of demonstrating that the Group's voices had been heard and respected, and were influencing change for future working. This could be seen in:

- Changes to the way SCC and the NHS delivered grant funding to make this less cumbersome;

- Genuine collaboration between officers and community organisations, using community insights to triangulate with public health intelligence data to deliver more effective targeting of community interventions, such as in the COVID-19 vaccination programme (see below); and
- Improved representation across high level leadership groups in Sheffield, such as Sheffield City Partnership Board, Sheffield COVID-19 Operational Group, Sheffield ICB and Sheffield Race Equality and Inclusion Group.

4.6 It is unequivocally the case that this work has been a success and delivered benefits for communities and public services. However it must be noted that as Sheffield continues to emerge from the pandemic response, there are potential challenges in maintaining it, as key staff are expected to put more time into their "day jobs", and community organisations that were central to its success are increasingly financially vulnerable, with lack of clarity on funding and risks around the impact of inflation and the broader cost of living crisis.

5.0 CASE STUDY 2: COMMUNITY CHAMPIONS

5.1 The Sheffield Community Champion programme was established to empower and support communities across the city to stay up to date with the latest advice about Covid-19. It has its roots in similar work focused on specific conditions, and aims to bring the learning from these to bear on this challenge.

5.2 Community Champions are active people in their communities, who have chats about health with family, friends and the wider community. They are given training and a chance to ask questions of experts to support this, and also share the feedback they receive about the realities of local health issues.

5.3 This work has been funded by the Department for Levelling Up, Housing and Communities through SCC and coordinated by SOAR, working through 11 VCS organisations, aiming to:

- Build strong links with communities where Covid-19 has most impacted
- Increase understanding by statutory agencies of local population needs
- Build strong relationships and engagement between communities, groups and local authorities
- Increase access to guidance of vaccination programmes and public health services

5.4 Work to date indicates that the programme is delivering on these aims, supporting people to access services by understanding their needs and responding accordingly.

5.5 Although the initial focus of the work was on COVID-19, it has become clear that there is demand for broader health support delivered in this way. Community Champions have been successful in supporting people access a broad range of services that they otherwise would not have, and in sharing learning with services to help them to learn and be more easily accessible in the future.

6.0 CASE STUDY 3: VACCINE HESITANCY

6.1 Vaccine hesitancy was already a key issue for the BAME community nationally, as well as in Sheffield, prior to the pandemic, and this was only made more important by the centrality of the COVID-19 vaccination programme to the pandemic response.

6.2 The low trust environment described above provides fertile ground for misinformation and rumours to spread and act as a barrier to people accessing the programme, and discussions in the BAME PH Group suggests this was an issue that needed addressing.

6.3 Through the BAME PH Group and Community Champions work, SCC used COVID grant funding to support organisations to deliver significant communications and engagement work on prevention and vaccination in a range of community languages and through trusted channels that the Council or NHS would not otherwise be able to reach, such as closed community WhatsApp groups, mosque broadcasts and community radio, community TV and other social media. It also supported the production of messaging from local Councillors in community languages, and from other well-known figures such as faith leaders.

6.4 The Group also supported the development of other interventions such as pop-up vaccination clinics, and arranging for primary care clinicians to invest time in talking to people to discuss their concerns and build trust in the programme.

6.5 Overall, Sheffield recorded the take-up of COVID vaccinations of all the Core Cities, with this work on vaccine hesitancy part of that success.

7.0 KEY POINTS FOR HWBB

7.1 There are a number of key points for Health and Wellbeing Board members to take from these case studies:

- COVID-19 exposed clearly the lack of trust and understanding that existed between BAME communities in Sheffield and statutory services
- The BAME PH Group and Community Champions work are examples of work that are making a difference to this, with Sheffield's vaccination programme demonstrating that they are delivering material benefits to health and care services in Sheffield
- The existing low levels of trust in services were a factor in lower use of services pre-pandemic
- Lower use of services when they are needed is a factor in the production of health inequalities
- This means trust is critical to good public service delivery, and to addressing health inequalities
- Trust is being rebuilt through this work but this is an ongoing task, and is not complete

- This work is vulnerable, both to expectations that key officers will return to business as usual work, and to the financial pressure on community partners
- This work has focused on ethnicity and BAME communities, but there are other communities with whom statutory services may have the same issues around trust and engagement, and where the same approach would be beneficial for services and communities.

8.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

8.1 Two factors have been critical to the success of this work:

- An identified individual representing statutory service(s) who is committed to the work, and empowered and supported to be so, and maintains involvement through challenging conversations to build relationships and trust; and
- A network of community organisations and leaders who are willing and able to commit their time and resource to the work, and whose contributions and views are valued.

8.2 Both of these are currently at risk due to work demands and financial pressures.

9.0 QUESTIONS FOR THE BOARD

9.1 The Health and Wellbeing Board are asked:

- Do the Board agree that the work described in the report is valuable, and should be maintained as Sheffield emerges from the pandemic and business as usual returns?
- How could this be resourced, and could the previous commitment to recruiting an Engagement Coordinator be revisited with this in mind?
- Do the Board agree that the lessons from the work described in this report provide the building blocks for an approach to engagement that can be applied more broadly?
- Do the Board want to explore this as part of a broader conversation about how we engage with, represent and build trust with communities across Sheffield?
- Do the Board want to take a joined-up approach to this by working with other partnerships and/or linking with best practice within our individual institutions?
- Do the Board want to explore options for how we could seek to build best practice through collaboration with funding and research bodies?

10.0 RECOMMENDATIONS

10.1 The Health and Wellbeing Board are recommended to:

- Agree that trusting relationships based on open engagement are a critical aspect of good public service delivery

- Sponsor a joint workshop with Sheffield City Partnership Board, and other partnerships that may be interested, to consider concrete next steps to learn from this and other work to improve engagement between public services and citizens in Sheffield, and to develop proposals to build capacity to sustain this work
- Revisit the previously agreed commitment to recruiting an Engagement Coordinator, considering whether this could apply across partnerships in light of the outcome of that workshop
- Sponsor the development of a proposition to put to potential funding partners to consider the links between effective engagement and health inequalities

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Impacts of Covid19 on Black, Asian and Ethnic Minorities - the Sheffield Response

Sarah Hepworth – Health Improvement Principal

Snapshot into Officer Experience

Covid19 Epidemic Sheffield – April/May

- Early indication of disproportionate impact on BAME communities in the city
- Indications of higher rates of virus transmission, infections, severe disease and death rates within BAME communities before it became a national agenda item
- Higher volume than usual of Muslim Burials
- There was some lack of Public Sector knowledge about our BAME Communities and Faith organisations and how to access them

PHE reports on Covid19 impact on risks and outcomes

Due to ethnicity not being recorded on the death certificates we do not have information on Covid19 deaths at a national and local level by ethnicity.

CMO asked PHE to undertake a review on why disproportionate impacts were occurring within BAME communities

- **COVID-19: review of disparities in risks and outcomes (2nd June) Epidemiological data**
- https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

- **Beyond the data understanding the impact of Covid19 on BAME populations PHE June 2020 (16th June)**
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

What we did and why?

- Raised by the co-chair at tactical group - asked for a BAME citywide response to Covid
- The ACP took responsibility for the BAME Strategy Group and looked at how BAME populations could be further protected
- This led to the creation of two sub groups- Communities and Workforce (risk assessments and representation)
- Communities strand to inform the Covid19 BAME Health Impact Assessment and mitigating actions and recovery response/ 2nd wave
- Lack of local data - on Covid19 infection rates, severe disease, hospital admissions and death by ethnicity. Lack of understanding of local impacts/lived experience meant it was vital to talk to BAME communities – needed to understand if these impacts were the same as national picture.

Who attends the group?

Over 25 BAME community organisations attend representing: Black - African, Caribbean and Somali. Asian – Pakistani, Bangladeshi and Chinese, Yemini, Minority Ethnic – Roma Slovak communities
:

- Faithstar
- Thalassaemia South Yorkshire foundation
- Firvale community projects
- Sadacca
- Shipshape
- Roshni Sheffield
- Ashiana
- Firvale Hub
- SACMHA
- Pakistani Muslim Centre
- Hallam Homecare Services
- Reach up
- African Voices
- African/Asian Women Health Group

- Somali Mental Health
- Director of MA Education Consultancy
- Unity Gym
- SCCCC
- Sickle Cell Anaemia
- Sheffield Chinese Community Centre
- Darnall Wellbeing
- FSB
- ISRAAC
- ACT

Statutory and VCF orgs who attend: CCG, ACP, SHSC, SCC, STH, SHC, VAS, Healthwatch, CAB

Methodology and ethos of group

- Co-chaired by Public Health and FaithStar – important as trust was already established with FS and some trust with PH due to response in pandemic
- Listen, learn, reflect, action
- Guest speaker , community questions
- Open, honest, transparent dialogue
- Action log and monitoring of progress to demonstrate change

Why are BAME populations being hit harder by Covid19 in Sheffield?

- **Covid19 has shone a light on existing inequalities and exacerbated these**
- A higher proportion of BAME communities live in areas of deprivation (38% vs 23% city average) including Burngreave, Firvale, Page Hall, and Darnall, Sharrow - these are amongst the 10% most deprived in the country. **Urban areas – densely populated.**
- ***These areas of the city have experienced a greater burden of disease from Covid19 than more affluent parts and have seen some of the highest death rates in the country.***
  - **Socioeconomic factors, housing** (multigenerational and overcrowded, Slovak community average 6 people per household and Bangladeshi 4.2) 15% have one fewer bedroom than they require compared to 5% Sheffield population
  - **Inequalities in the prevalence of heath conditions** that increase the severity of disease including obesity, diabetes, CVD and asthma (GP practice level data only not by ethnicity)
  - **Inequalities in prevalence of health behaviours** - smoking, obesity, alcohol and PA uptake linked to economic deprivation and prevalence of health conditions (no data by ethnicity locally no annual data by ethnicity nationally)
  - **Occupational risk, (key worker roles)** Taxi drivers, social care, chefs, less likely to be able to work from home and insecure roles more likely to be shut down (self employed)
  - **Historic racism, discrimination and stigma, - structural inequalities, lack of power and voice**
  - More likely to use public transport to travel to essential work
  - **Less likely to seek health care when needed** – lack of trust in NHS to meet their needs due to lack of representation in services – lack of cultural appropriateness (late presentation across a range of conditions) – more reliance on local BAME community services

Unpacking the relative contributions made by different factors is challenging as they do not all act independently – these increase risk of exposure to the virus and risk of severe disease/death

Key impacts- lived experience

- **Confusing communications and misinformation** on PH Covid19 messaging national and local – looking to friends, social media and country of origin rather than trusted sources of information – Lack of trust with Govt, NHS council
- **Language barriers** (health literacy and interpreting issues) – very little info in different languages in early stages of epidemic
- **Hoax rumours circulating included:**
  - BAME communities being used as Guinee pigs for vaccination research,
  - If BAME people go to hospital for treatment for any condition you will get Covid19, they will inject you with it
  - If you go into hospital due to COVID19 you won't come home again
  - White people will be given preferential treatment if oxygen supplies are limited in hospital
  - Covid does not even exist – just a way to control BAME communities
- Communities told us that people were frightened to attend appointments at the hospital/GP for fear of getting Covid19.
- We heard of people presenting later with Covid19 severe symptoms due to the latter and also not presenting early with heart attacks
- Families did not want seriously ill relatives to go into hospital for Covid treatment due to fear of loved ones dying alone

Key Impacts - lived experience

- **Mental Health** Issues (older and young people) – increasing, complex multifactorial
  - BAME organisations not equipped to deal with complex SMI cases and suicide ideation/attempts but stepped up to high demand. Referrals on long waiting lists and services not accommodating cultural beliefs and practice – these inhibit willingness to access support
  - Anxiety, depression at it's height about the virus and increased risk and infection

Isolation- older people- usually reliant on sense of community from family, places of worship coming together, lunch clubs

- **Frontline care and access** – didn't know who to contact - how to refer or plug people into services (NHS and Council)

- **Food parcels/food security** - access to culturally appropriate food limited
  - Only 5% of BAME people accessed SCC food provision (started late to record E and D info)
  - Response from communities was widespread – hot and cold food boxes provided into their hundreds using their own resources

Key impacts - lived experience

- **Education issues** – children falling behind - who already fair less well– parents not understanding how to support due to complex online learning systems and language barriers. High anxiety sending children back to school and potentially bringing the virus home to multi- generation families

- **Poverty – employment and loss of jobs,** a number of self employed people in BAME communities did not access support due to lack of trust with the council and complex national process**.** 40% of people CAB supported were BAME

- **Bereavement –** not able to carry out usual burial and religious rituals and ceremony – places of worship closed – source of community and support. Larger impact of loss exacerbated fears.

- **Domestic Abuse** – higher contact with BAME organisations Roshni and Ashiana than usual. The proportion of BAME referrals to mainstream services has dropped however referrals have risen overall – impacts of lockdown exacerbated domestic abuse and coercive behaviour and control. Demand outstripped capacity.

BAME Community Organisations

- Loss of BAME community organisations over the last 10 years meant that the reduced number that currently exist were overstretched and under resourced to meet demand and need.

- Impact of austerity on BAME community services – funded mainly from external sources outside of the city – inconsistent contact with the key decision makers in the council and NHS directly for some of organisations for many years

- Lack of investment in infrastructure and capacity building meant that many funded their own local response

- BAME VCF sector felt neglected and voiced that they did not feel that Anchor VCF organisations in the city represented them or reached their communities – this impacted on unequal access to funding and relationships within the Vol sector

- Demand for support and services from community organisations far exceeded that which they were able to deliver to BAME communities

Our response

- Initially met weekly and moved to 2 weekly meetings after xmas
- Over 30 meetings since July 2nd 2020 to June 2021
- **60 hours of collaboration,** discussion, reflection and learning – many more hours outside of the group
- **Covered around 23 different topics related to covid** from government guidance, prevention, Hands Face Space, ventilation – testing, isolation, vaccination – long covid – business grants, faith, mental health, travel restrictions, covid variants and much more around wider impacts on inequalities, education, racism, and social justice
- SCC funded organisations to deliver significant communications and engagement work on prevention and vaccination in a range of community languages and channels the council/NHS alone would not be able to reach
- E.G. closed WhatsApp groups, mosque broadcasts and community radio, community TV and social media

Meeting Date	Agenda items and attendees
2-7-20	Listening to BAME community organisations lived experience during covid19 epidemic
9-7-20	Decision maker John Macwraith SCC Exec Director Peoples services - communities commissioning
13-7-20	Head of SCC Comms, Mark Mcadam Comms and misinformation
20-7-20	Brian Hughes Accountable Officer Sheffield CCG Paul Taylor Head of Customer Services Covid19 Memorial,
6-8-20	Mental Health Services and provision Liz Johnson Equalities lead and Jason Rowlands Director of Strategy (SHSC)
13-8-20	RACE Equality Commission Chair Prof Kevin Hylton Susan Hird Consultant in PH (TTI)
20-8-20	Education, Andrew Jones SCC Director of Education and Bethan Plant, Health Improvement Princiapl (PH)
3-9-20	SCC Public Health, Jess Wilson Food and Obesity lead for the city. Food strategy, SCC Holiday Hunger programme, SCC comms resources available

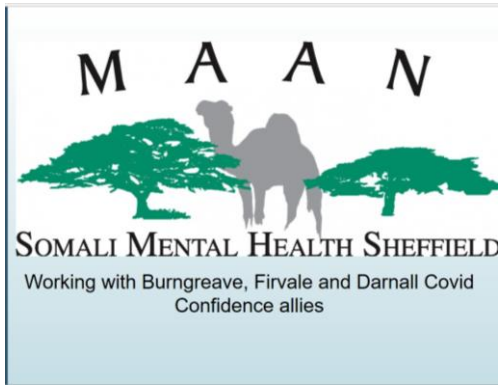
Impact of the group & development of Trust

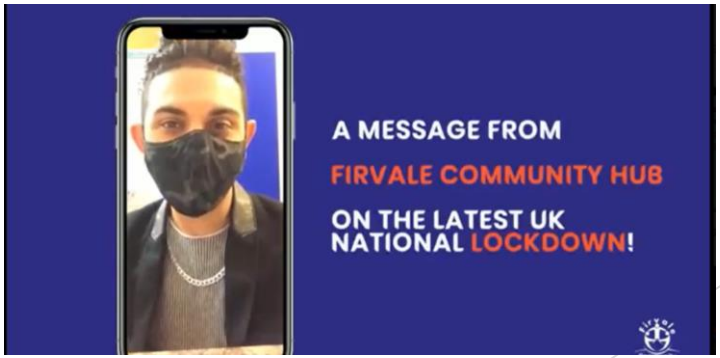
- These meetings have proven that the BAME communities are not hard to reach and they are here. It is a great platform to share information and ways people are working in helping their communities. It has been amazing to work together and play a vital role. It has made such a difference to feedback and shape the city. It really has changed the voice of BAME communities.
- It really has raised the issue people are facing daily. It has been great to work in partnership with others.
- These meeting have helped build the trust between local authorities and communities. Peoples heart are now in the right place, Thank you.
- The collaborative, participatory approach has been excellent
- Brilliant collaborative and reflective approach to community work.
- We have felt really heard. It has been such a powerful and important space.
- This journey has been epic, such a good practice model and should be replicated in other spaces in the city.
- I have grown in confidence and it has been important for my own journey. I have access to more professionals than ever before this has strengthened my work and my own practice. Also we (the community organisations) are collaborating working to understand how we can work better together. Lots of us had not done this in years,
- Pro-activeness and participation has been key going forward well done everyone

Impact of the group & development of Trust

- This is one of the only safe spaces in the city for us to have these important and difficult conversations
- This meeting space has been great, and the journey has been vital.
- It has been a great opportunity to work with other organisations. So much information and vital messages has come from this group.
- A requirement and essential
- The last 9 months have been a hard journey for all, fighting inequalities together. Being able to build connections with others has been really positive.
- The group have been supportive, and it has been great to meet and work with other local BAME organisations in the city. It is a good space to share information and help one another
- Looking back over the past nine months, it has been fantastic to listen and learn from other local BAME organisations. The space given has been really uplifting.
- The meeting has been active along with visible learning. There have been many frank discussions that are needed. Finally, the trust gap is closing.

Prevention work



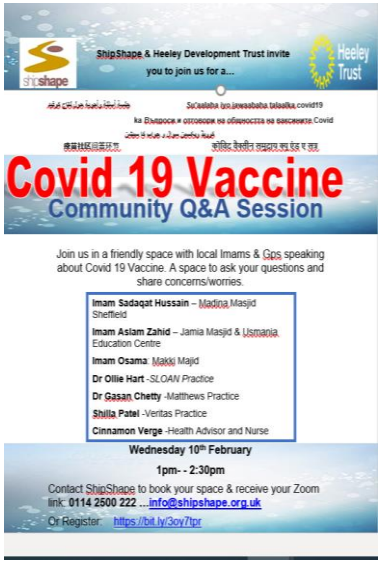


Social media promoting vaccination and covid safe behaviour

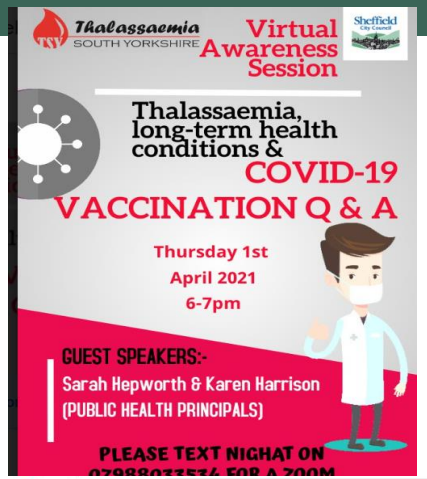
Community Newsletter

- Webpage set up for easy access to national and local resources including translations
- www.sheffield.gov.uk/coronaviruscommunityresources
- Simple clear communication resources developed by SCC Communications Dept for communities embedding community insight
- Weekly community newsletter with 600+ subscribers for sharing key messages

.


ShipShape & Heeley Development Trust invite you to join us for a....
Covid 19 Vaccine
Community Q&A Session
Join us in a friendly space with local Imams & Gps speaking about Covid 19 Vaccine. A space to ask your questions and share concerns/worries.
Imam Sadaqat Hussain – Madina Masjid Sheffield
Imam Aslam Zahid – Jamia Masjid & Usmania Education Centre
Imam Osama. Makki Majid
Dr Ollie Hart -SLOAN Practice
Dr Gasan Chetty -Matthews Practice
Shilla Patel -Veritas Practice
Cinnamon Verge -Health Advisor and Nurse
Wednesday 10th February
1pm- - 2:30pm
Contact ShipShape to book your space & receive your Zoom link: 0114 2500 222 ...info@shipshape.org.uk
Or Register: https://bit.ly/3oy7tpr

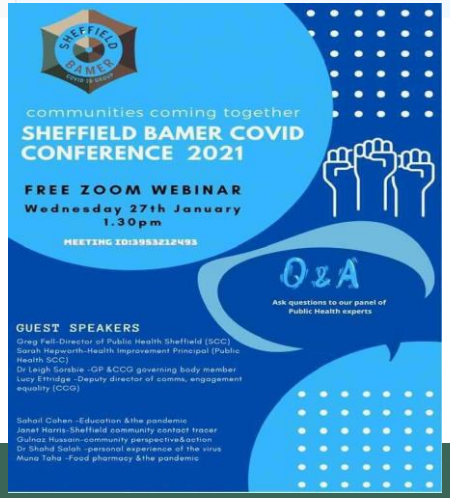

KOTV
LIVE
THE VOICELES
Advice Show with Mohammad Maroof

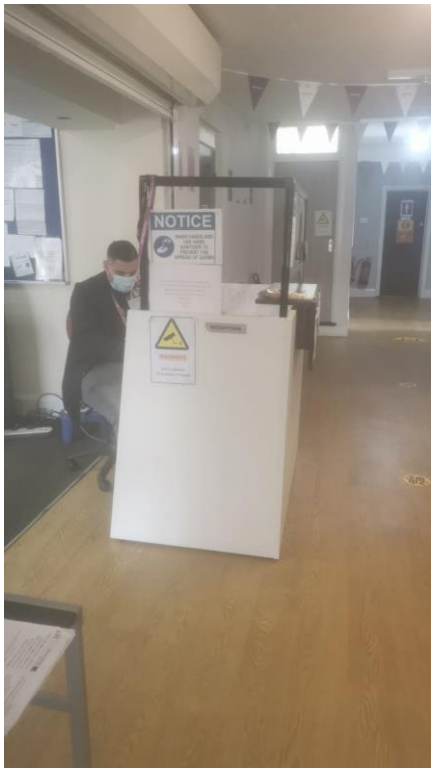

Thalassaemia SOUTH YORKSHIRE
Virtual Awareness Session
Thalassaemia, long-term health conditions &
COVID-19
VACCINATION Q & A
Thursday 1st
April 2021
6-7pm
GUEST SPEAKERS:-
Sarah Hepworth & Karen Harrison
(PUBLIC HEALTH PRINCIPALS)
PLEASE TEXT NIGHAT ON


YouTube
Search
COVID-19 vaccine
Get the latest information from the NHS.
LEARN MORE


This webinar is hosted and facilitated by FaithStar
VOICES FROM THE EDGE
Community participation in vaccine development, program delivery and implementation.
THE AIM OF THE WEBINAR
to create a space for dialogue and exploration of the issues and opportunities facing communities in the development, program delivery, and implementation of vaccination programs from seldom heard communities in Sheffield.
A WEBINAR TO EXPLORE THE FOLLOWING AREAS.
Vaccine development
Under representation of marginalized communities in clinical trials
Mistrust and vaccine hesitancy
What does the future hold for collaborative working?
INCLUDING COMMUNITY LEADERS AND REPRESENTATION FROM PUBLIC HEALTH, NHS CCG AND PFIZER AS PANELLISTS


YOUR CONCERNS HEARD & ANSWERED BY TRUSTED LOCAL LEADERS AND MEDICAL PROFESSIONALS
ISRAAC CENTRE PRESENTS
ZOOM COVID19 VACCINE Q & A FOR THE SOMALI COMMUNITY & OPEN TO ALL
SHEIK MOHAMED ALI
DR SHADIA AHMED
CINNAMON VERGE
JILLIAN CREASY
SAFIYA SAEED
THURSDAY
MARCH 25TH
1.30-3.00PM
JOIN THROUGH EVENTBRITE OR HTTPS://ISRAAC.ORG.UK/ OR LINK ON REQUEST FROM INFO@ISRAAC.ORG.UK OR TEL: 0114 278 7662

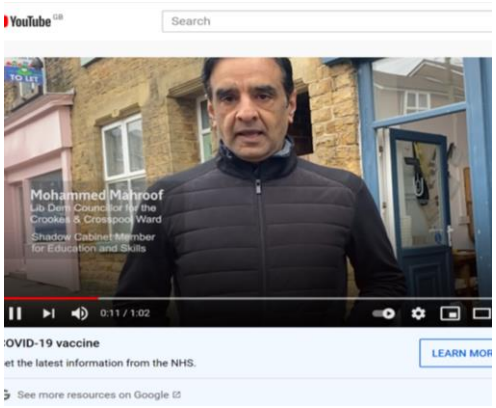

communities coming together
SHEFFIELD BAMER COVID CONFERENCE 2021
FREE ZOOM WEBINAR
Wednesday 27th January
1.30pm
Q&A
Ask questions to our panel of Public Health experts
GUEST SPEAKERS

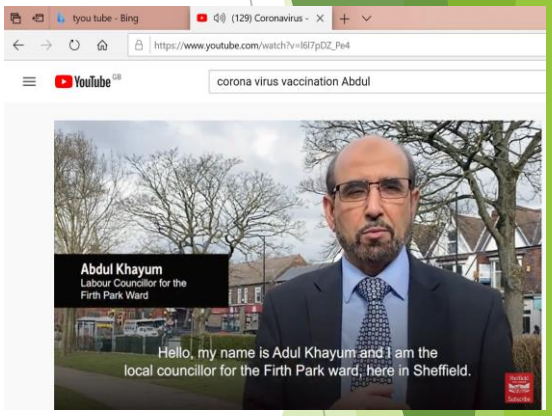


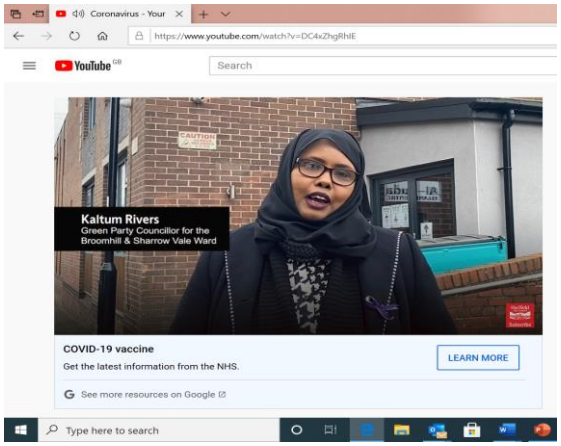
Vaccination pop up clinic at Firvale Hub for ROMA Slovak Community – 50 booked in via community engagement

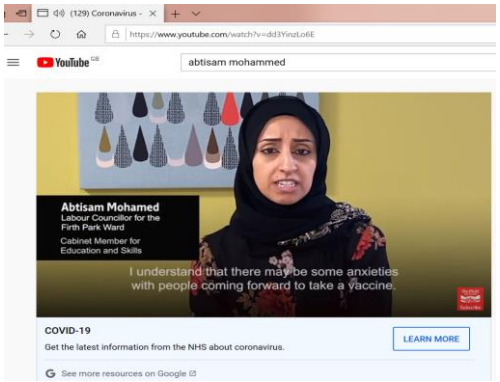
Councillor video's vaccine hesitancy

- SCC Councillors Mohammed Mahroof, Kaltum Rivers, Abtisam Mohamed and Abdul Khayum have filmed video's in community languages and these can accessed via Youtube





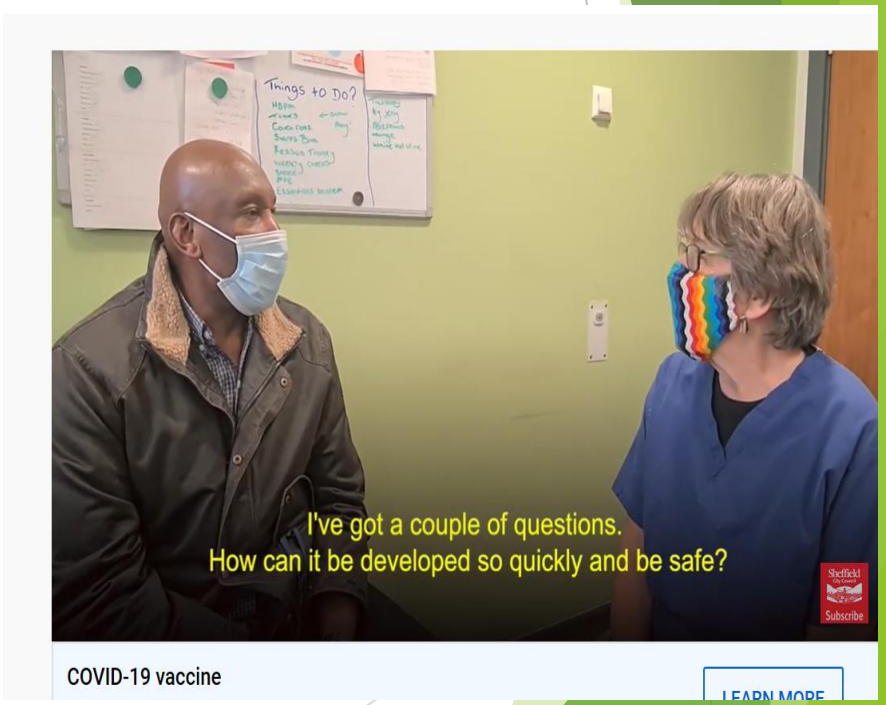




https://www.youtube.com/watch?v=DC4xZhgRhIE

Uri Rennie – vaccination video

- Uri Rennie (retired English football referee) during his covid vaccination, discusses vaccine hesitancy with the GP administering his vaccination.
- Uri is a trusted, well respected member of the African Caribbean community and his video aimed to help reduce vaccine hesitancy.
- He is determined to do more than 'talk the talk' in trying to use football as a vehicle to bring about change.



https://www.youtube.com/watch?v=3SDN7XAW6wQ

Covid19 Vaccination Young Adults campaign targeting 18-35 years (launched 14th June 21)

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Vaccinate Sheffield In...

Faith leader comms and engagement

- Faithstar established Faith Covid group
- Established links with health protection, PH and SCC enforcement teams (covid secure POW)
- PH support re interpreting Government guidance and developing local Muslim burial and funeral protocols
- Communications - social media key messages, community radio shows on staying safe during Easter, Ramadan, Eid and Christmas.
- Letter from DPH Greg Fell and leader of the council to local faith leaders Video's from DPH on current safety measures
- Faith leader vaccination video's by Faithstarhttps://www.youtube.com/watch?v=ppvKThCn5CA


E Mail: Greg.Fell@sheffield.gov.uk
Date: 1st April 2021

Sheffield City Council

Town Hall
SHEFFIELD
S1 2HH
Telephone: (0114) 273 5380

Members

all our Muslim communities a happy with how they have come together and is very special to see.

imes we have had to face as a city, and amadan. Sheffield communities have ic.

and the incredible support that you have

E Mail: Greg.Fell@sheffield.gov.uk
Date: 1st April 2021

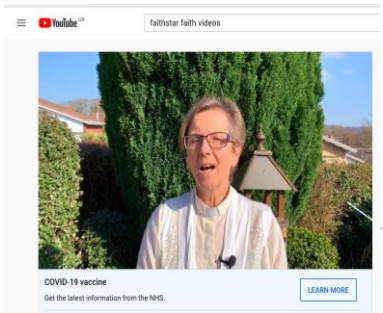
Sheffield City Council

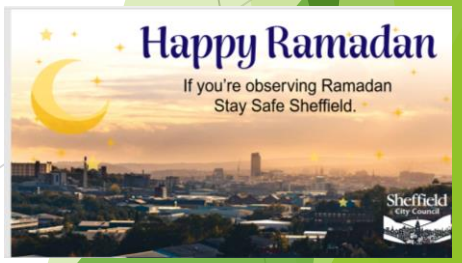
Town Hall
SHEFFIELD
S1 2HH
Telephone: (0114) 273 5380

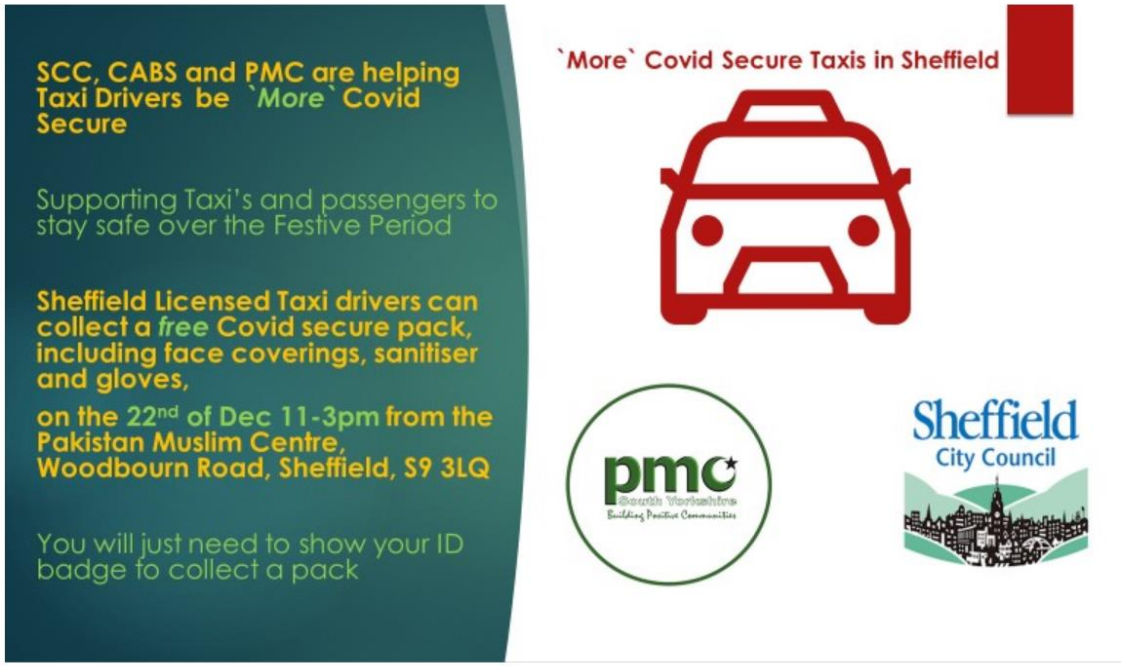
Dear Respected Clergy/Trustees/Management Committee Members

On behalf of Sheffield City Council, I would like to wish all our Christian communities a happy Easter. People across our city continue to amaze us with how they have come together and supported each other through this extraordinary year. It is very special to see.

The community spirit lives on after one of the toughest times we have had to face as a city, and I know that this will continue throughout Easter. Sheffield communities have shown incredible resilience during the Covid19 pandemic.

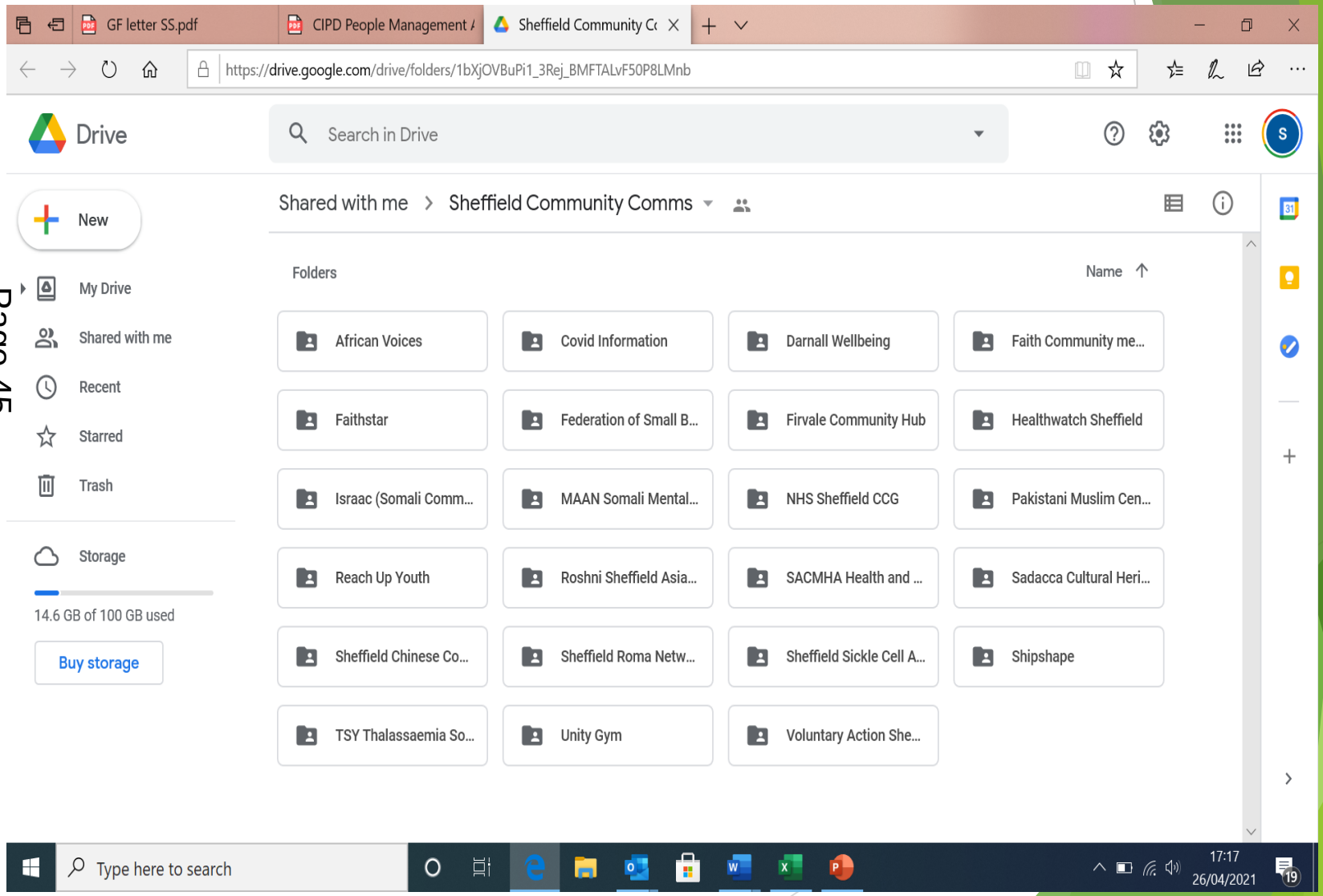






More Covid Secure Taxi Initiative with PMC and CABS

Google Drive
https://bit.ly/SheffCommunityComms



National media spotlight on our work:

- BBC Article from Newsnight – with support from Firvale Community Hub The 'working poor' are hardest hit, Sheffield study finds - https://www.bbc.co.uk/news/health-56334982

- Greg talked about the Sheffield approach to reducing vaccine hesitancy in BAME communities on ITV Calendar
- https://twitter.com/AdamFowlerITV/status/1369973610140557312?s=20
- https://twitter.com/AdamFowlerITV/status/1369969576251887616?s=20
- https://twitter.com/AdamFowlerITV/status/1369972350250053?s=20

Covid: Pfizer joins fight to tackle vaccine hesitancy

- https://www.bbc.co.uk/news/uk-england-south-yorkshi 56927168

Outcomes achieved so far

- Re-establishment of trust between communities the council leaders and NHS
- Group members report not feeling marginalised due to the links made via the group and access to information and influencing local decision and services (A&E/Social Care/Carers/Mental Health Suicide prevention)
- Feeling heard and represented by decision makers (Sarah Hepworth/John Mac/Greg Fell and Brian Hughes)
- BAME organisations working more collaboratively together (e.g BAMER 5) vaccination proposal to SCC and NHS – allowed advocacy for funding
- Direct routes into communities re communications and messages, result = many lives protected but we will never be able to quantify
- Funding in excess of around £500k to BAME communities to deliver covid prevention /vaccination work from the Council and the NHS
- Increase in people reporting less hesitancy and intention to take up the vaccination following community conferences and conversations examples across all communities
- BAME representation at the Sheffield First Partnership (Halima from the African women's group in Darnall) and new joint VCF SCC steering group

Outcomes achieved so far

- Citywide Maternity Fund Bid led by MCDT and inclusive of several BAME organisations from the PH group (focus on Perinatal Mental Health)
- Thalassaemia organisation lead new role with British Islam Muslim Association
- Shaping Research on representation of BAME communities and informing local and national research bodies NIHR and Royal College of GP's, Pfizer conference
- Establishing links between community organisations PCN'S and local schools/faith leaders
- Citywide response to racist behaviour targeting Chinese community re covid – Community orgs, NHS, SCC and Universities etc workforce and community response.
- Wider access and relationships to faith groups and community leaders
- Relationships with many professionals across the ACP footprint and BAME communities
- ACP Reciprocal mentoring Scheme with BAME community leaders and chief execs in the city (STH SHSC SCH and SCC)
- Three of our group members are Commissioners on the Sheffield Race Equality Commission and continue to feed in issues from the group

These issues and outcomes are Intersectionality important and we know other communities have been badly impacted and we should replicate the model across other areas/groups e.g. Disabled people

Charted Institute for Professional Development
People Management Awards 2021

Developing Partnerships
Best Community Initiative Category

What next? and ongoing?

- Commitment to continuing **the dialogue with BAME organisations and building on the trust** developed
- Review and Implement **TOR for group and recommendations** within the BAME Impact Assessment with robust action plans that clearly set out how these will be achieved – including the previous commitment to deliver the 7 PHE recommendations and ACP asks
- How will we as a city address the issue of lack of **data by ethnicity groups across social, health, economic and environmental factors**? Urgently need prevalence of health conditions, and health behaviours by ethnicity. Intersectional data also.
- **Address the inequity in disease and health behaviour prevalence and ensure people are managing their conditions**
- **Empower and involve BAME voices** from the community in the development of strategies, services/interventions, policy, communications and health education campaigns that involve them
- **Support and develop capacity building within BAME community organisations and invest in the infrastructure of BAME community organisations** in the city to enable them to be more resilient and deliver effective frontline services
- **Ensure NHS and Council services are representative, culturally appropriate and inclusive (including relevant training across the system)**

SHEFFIELD COMMUNITY CHAMPIONS

APRIL - AUGUST 2022

BY ROSE BATTY
SOAR COMMUNITY

Aspiring Communities Together Community Champions

About

The Sheffield Community Champion programme has been established to empower and support communities across the city to stay up to date with the latest advice about Covid-19. Funded by Ministry of Housing, Communities and Local Government through Sheffield City Council and coordinated by SOAR Community, the programme works with 11 fantastic VCS organisations. Community Champions are made up of active people within their communities who have health chats with family, friends and the wider community. Champions are given training and a chance to ask questions to the experts and share feedback into the realities of local health issues.

Aims

- Recruit volunteer Community Champions from the communities we're working with
- Equip volunteers/communities with correct information to support them in making positive health choices
- Build strong links between the Government and communities where Covid-19 has most impacted
- Increase understanding by statutory agencies of the local population needs
- Build strong relationships and engagement between communities, groups and local authorities
- Increase access to guidance of vaccination programmes and public health services

A Zest Community Champion attended our Women's Group and was able to share diabetes information. One lady said *"thank you for sharing, I learnt so much from attending this event and have now booked in for a GP appointment."*

How

- Peer engagement
- Share clear and consistent health messages
- Listen to questions and concerns
- Help people access services e.g., vaccine clinics, GPs etc
- Conversations with family and friends
- Attend social cafes and coffee mornings
- Use social media platforms e.g., WhatsApp
- Leafletting
- Stalls
- Door to door conversations
- Healthy Holidays and other group sessions

Definition of Peer Engagement: *A person with equal standing in a community who share a common lived experience.* [1]

Ti L,Tzemis D, Buxton JA. Peer engagement in the context of policy and program development: A review of the literature Substance Abuse Treatment, Prevention, and Policy (2012) 7:47 http://www.substanceabusepolicy.com/content/7/1/47

Firvale Community Hub Community Champions

Champion Training

Delivered by Sofeena Aslam (SOAR Community):

- Covid-19 Confidence
- First Aid
- Health chats
- STEPS course
- Vaccine confidence

In the pipeline:

- Advanced care planning
- Cost of Living support
- Digital skills
- Menopause

"The cancer awareness program was excellent and informative. I feel it is very important for our community to have as many trained Champions to empower them with reliable and correct information about the services the NHS and other organisations provide to the public."

- Zest Community Champion

81

active champions

1,729

hours of volunteering

362

hours of champion training

9

champions have left for employment

> *As a Champion, the sharing of experiences of accessing healthcare treatment can be very valuable; hearing what has worked and where services are available. Even the negative experiences are useful to share and be heard, hopefully in these spaces we can offer mutual support and begin to find solutions. It is in these gentle conversations that important issues come to light and the Community Champions programme allows a structure to be able to reflect these very real problems back to healthcare officials to be better able to address them.*

- Lucy Halstead,
Community Champion for Sharrow Community Forum

Conversations

Conversations on additional health issues include:

- Access to health care - struggles getting a GP/Dentist appointment
- Blood pressure
- Cancer
- Cost of living and fuel poverty
- Covid-19
- Dementia
- Diabetes
- Loneliness
- Maternity case
- Menopause
- Mental health
- Monkey pox
- Substance use

Maria had recently suffered a miscarriage. When chatting to one of our Community Champions, it came to light that she was still in some physical discomfort as well as emotional discomfort. Our Champion was a listening ear and Maria spoke at length about how she was feeling and what kind of support she had. Our Community Champion was able to signpost Maria to a bereavement counselling service as well as Jessop's miscarriage support services.

- Sharrown Community Forum Case Study

6,643

conversations with the community
(April - August 2022)

5,116 / 77%

from African Caribbean, Pakistani, Romanian, Slovak, Yemeni, Somali and other communities

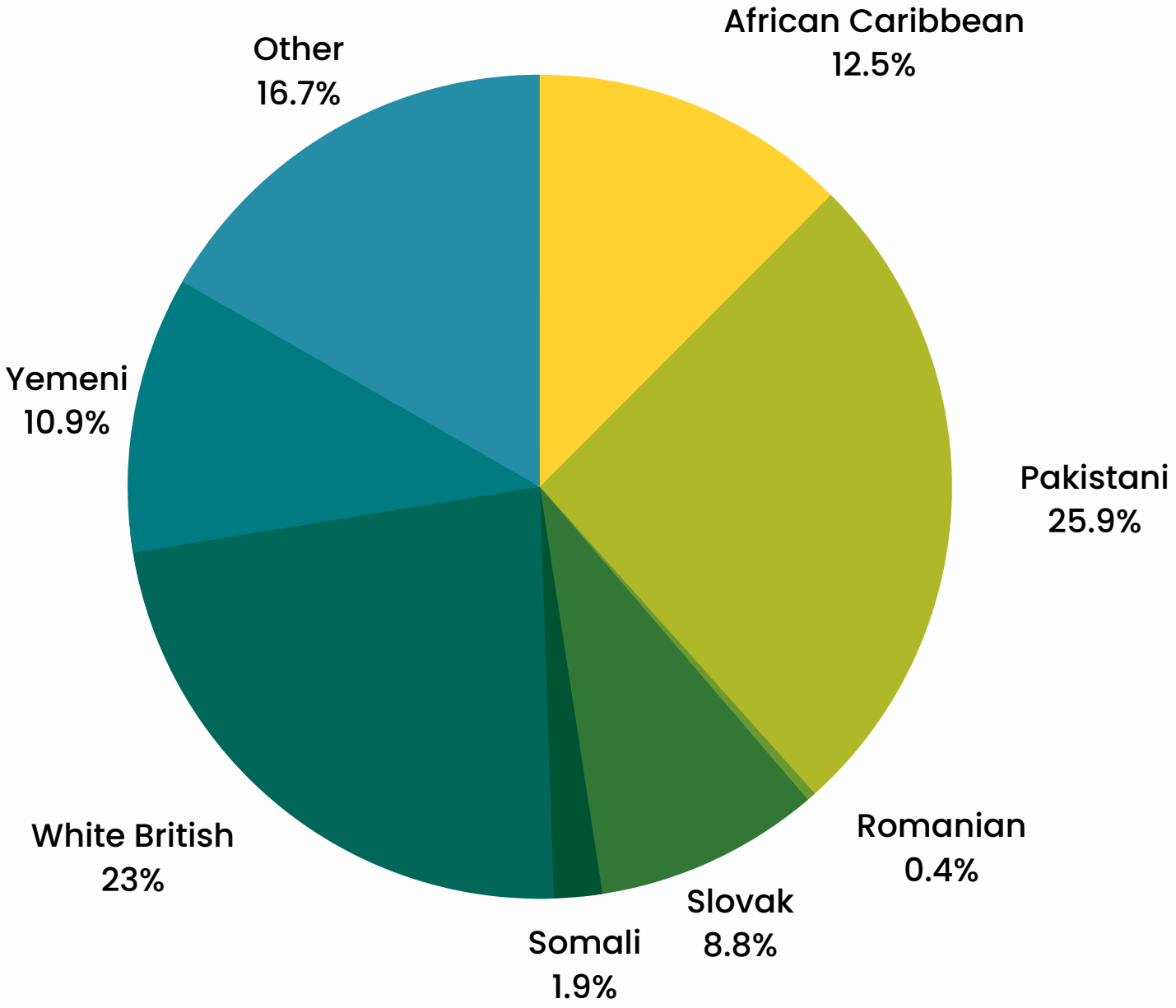


Figure 1 - a breakdown of ethnicities

Other includes Albanian, Arabic, Bangladeshi, Bulgarian, Canadian, Indian, Kurdish, Libyan, Turkish

510

conversations under 18-year olds

5,095

conversations 18-65-year-olds

1,038

conversations 65+year olds

Aaliyah chatted to one of our Community Champions last year about Covid-19 and was reluctant to take the vaccine. However, in November she caught it and was very ill. The experience left her traumatised. She waited 3 months and got her first dose of the vaccine. Since recovering from Covid she has developed anxiety and stopped leaving her house.

Connecting with a Firvale Community Hub Champion, Aaliyah is building her confidence back up. She is now a part of the Live Lighter 12-week weight management programme and has been regularly attending a Social Café. A highlight for Aaliyah so far has been joining a group of women to go on a walk around Dam Flask. She's also booked on to receive her second Covid vaccine. She said "being around other people has helped overcome my (vaccine) hesitancy. I feel less stressed and anxious about leaving my house and on the whole, feel so much better for going on regular walks with the group."

Primary Care Networks

Number of conversations had per PCN

571
City Centre

3,648
Foundry

1,695
Heeley Plus

93
Peak Edge

434
SAPA5

202
Seven Hills

Learning

- Recruiting Champions that are relatable and already embedded within their local community has been effective
- Champion approaches are highly relevant to reducing health inequalities
- There is a noticeable fatigue in people wanting to discuss Covid-19 in general
- Conversation are changing & the programme must adapt
- Funding partners must be sustainable
- Communities are listening to the Covid-19 messages but want support in other health matters – Champions are supporting and signposting where they can

> ***Improving access to health and social services within the African Caribbean community improves outcomes therefore the work that we have the privilege of doing is invaluable.***
>
> - SACMHA Community Champion

Phase 3 Suggestions

- Continue to feedback to services, such as public health, to help better understand the community needs and to activate change
- Be led by the needs of the community to influence champion training
- Develop the coproduction of the programme
- Encourage quality over quantity in monitoring/showcasing outcomes
- Develop the champion learning circle to encourage citywide volunteer networking
- Continue to engage champions in training opportunities

The work we have championed during the pandemic has helped so many people in the community. I am proud to be a community champion in Sheffield!

- Sudki Eidaroos,
Aspiring Communities Together Community Champion

Produced August 2022

Many thanks to:
Aspiring Communities Together
Darnall Wellbeing
Firvale Community Hub
Flower Estate Family Action
Heeley Trust
Longley 4 Greens
SACMHA
Sharrow Community Forum
The Terminus
SOAR
Zest
Sheffield City Council

If you would like to discuss the Sheffield Community Champion programme further, please contact Rose Batty (Programme Coordinator) rose.batty@soarcommunity.org.uk

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health, SCC
Date:	29th September 2022
Subject:	Progress towards becoming an intelligence-led, Compassionate Sheffield
Author of Report:	Eleanor Rutter – Consultant in Public Health

Summary:

This paper sets out for the Health and Wellbeing Board the progress made in relation to 'Compassionate Sheffield' and taking an intelligence-led approach to it. Detailed information regarding specific projects is included in the paper which ends by asking the board for ongoing support including financial resource which it is recommended they ask the Sheffield Joint Commissioning Committee to take this forward as part of Sheffield's programme of integrated commissioning.

Questions for the Health and Wellbeing Board:

- We ask the board to note the work that has been done in a relatively short period and challenging circumstances. Does the board agree that this work is an important foundation to achieve the ninth ambition of the H&WBS and as such, does it sponsor its continuation?
- Will the board agree to receive further updates in due course – after a period of sustainable funding?
- Can board members refresh individual organisational commitment to the integrated intelligence approach?

Recommendations for the Health and Wellbeing Board:

- We recommend that the H&WB board asks the Sheffield Joint Commissioning Committee if they will take this work forward as part of Sheffield's programme of integrated commissioning.

Background Papers:

https://democracy.sheffield.gov.uk/documents/s36621/Item%204%20-%20End%20of%20Life.pdf

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Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

Ambition 9: Everyone in Sheffield should live the end of their life with dignity and in a place of their choice.

Who has contributed to this paper?

Sam Kyerematenng – Consultant in Palliative Care and Medical Director, St Luke's Hospice

Nick Deayton – Programme Manager, Compassionate Sheffield

Chris Gibbons – Public Health Principle

Progress towards becoming an intelligence-led, Compassionate Sheffield

1.0 SUMMARY

This paper sets out for the Health and Wellbeing Board the progress made in relation to ‘Compassionate Sheffield’ and taking an intelligence-led approach to it. Both projects suffered significant delays, due to loss of staff leadership capacity during the pandemic, but both have also made significant progress. Detailed information regarding specific projects is included in the paper which ends by asking the board for ongoing support including financial resource which it is recommended they ask the Sheffield Joint Commissioning Committee to take this forward as part of Sheffield’s programme of integrated commissioning.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

A good end-of-life experience is said to be one where all physical, social, psychological and spiritual needs are met. Sadly, not everybody can expect to have their needs met optimally by the current system in Sheffield. By gathering stories in communities and marrying those up with quantitative data sets we can have a better understanding of who is having a good experience and who is not. By working first in communities least likely to have the best experiences and helping people to learn to use compassionate language and finding the confidence to offer, and to ask for help, we can hope to reduce the inequalities experienced at the end-of-life.

Progress towards becoming an intelligence-led, Compassionate Sheffield

1. Background

In 2019 Sheffield’s Health and Wellbeing Strategy was refreshed, with an overall aim of eliminating the gap in Healthy Life Expectancy across Sheffield. It took a life-course approach, with nine ambitions. The last of those ambitions was to ensure that ‘everyone in Sheffield could live the end of their life with dignity and in a place of their choice’. This recognised that there is wide variation in experiences at the end-of-life in Sheffield – some are excellent, others, sadly, are not. Additionally, a paucity of high-quality intelligence in this area makes it hard for us to know who in Sheffield has a good experience or what, specifically constitutes a bad one.

A good end-of-life experience is said to be one where all physical, social, psychological and spiritual needs are met; it is known that good preparation improves that experience. A ‘medical model’ of death and dying would often view that preparation as something that happens between patients and professionals, which begins when the end of life is approaching.

A public health approach to death, dying and bereavement includes everyone affected by death and uses all of life’s challenging experiences to prepare by: learning to use compassionate language and finding the confidence to offer, and to ask for help.

In practice, this approach allows communities and neighbourhoods to support individuals and families when they are at their most vulnerable. This has become known as a Compassionate Community approach.

In September of 2019 the Health and Wellbeing Board supported the development of a three-pillared approach to delivering the ninth ambition, namely:

- Developing Sheffield as a Compassionate City
- Taking an intelligence-led approach, and
- Transformation of clinical pathways.

The link to the full paper is given on the coversheet

2. Purpose of this paper

The purpose of this paper is to update the board with regard to progress of the Compassionate Sheffield project and the intelligence work, and to lay out some of the challenges and proposed next steps.

(NB: The 'Transformation of Clinical Pathways' element has made good progress and has been reporting to the HCP).

3. Compassion

Compassion can be misunderstood in two particularly unhelpful ways: it can be viewed as a version of 'kindness' and as such, too soft and fluffy to deliver transformational change, and/or as a natural, human reaction, common to us all: a free resource. It is neither.

Broken down into its component parts:

- Listening *in order to learn, understand and empathise*
- Taking *appropriate* action
    - it can be seen that compassionate approaches have the power to transform individual relationships, organisations, neighbourhoods and communities.

However, as with any significant change, resource is required to support and deliver it.

4. The Sheffield Compassionate City Project Partnership

Following a hiatus caused by the leaders of this work necessarily focussing directly on the pandemic response, the Sheffield Compassionate City Partnership came together in April 2021, initially to oversee recruitment and then to steer the work of the Programme Manager who began in post in August 2021.

At its outset it was constituted by partners who were contributing resource to the work, namely: Sheffield Clinical Commissioning Group (SCCG), St. Luke's Hospice, Sheffield Hallam University's Lab4Living and Sheffield City Council's (SCC) Public Health (PH) service. The work of the partnership has been supported financially by SCCG, St. Luke's Hospice and SCC PH.

The partnership now employs a programme manager and two community development workers (both started in post in August 2022 and work 4 days per week) – all employment contracts are hosted by St. Luke's.

5. Achievements to date

5.1. Compassionate City Project

5.1.1. Development of an identity

Compassion spreads in many ways, not least as a social movement, where people want to be part of something bigger than themselves. This is aided if there is a strong and simple sense of identity. A visual identity and some key messages for communications have been developed.

Compassionate Sheffield
Small things, BIG DIFFERENCE

Barely a year old, 'Compassionate Sheffield' has gained both visibility and traction. This is evidenced by the fact that partners get approached about it in relation to a myriad of situations.

Compassionate Sheffield was founded within the context of death, dying, loss and bereavement. However, the principles can be applied to any context. Organisationally agnostic, it is a movement for Sheffield that has the value of 'compassion' at its core.

5.1.2. Advance Care Planning

Advanced Care Planning (ACP) helps people plan for the end of their life and is an important way of ensuring that services support the wishes of individuals. Primary care data highlights inequalities between different communities' engagement with ACP. This disparity drives inequity of experience for people in Sheffield.

Part of the reason for communities not engaging with ACP is a lack of information relevant to 'non-white British' people. Another crucial element is that primary care services do not have sufficient capacity to spend enough time to truly empathise and understand the relationship that these communities have with death.

Working with OPUS Independents and NHS Foundry Primary Care Network, Compassionate Sheffield are connecting targeted communities into the topic of 'Advance Care Planning'. By having conversations and facilitating workshops, we are supporting primary care services to work more effectively with Pakistani, Yemini and Roma communities.

The process will generate short videos, specific to each community that will provide tailored information on ACP. The videos will be made from the perspective of both people in the community and NHS services and will provide relevant information for communities and for primary care services.

5.1.3. Covid Memorial Project

Compassionate Sheffield are co-ordinating the city's Covid Memorial activity in partnership with Sheffield City Council and others. To ensure the city's memorial activity is representative of the experiences of people and their communities three core elements have been designed.

- *Stories from the Pandemic*: Gathering stories from people across Sheffield and taking targeted action to capture the stories of people who were disproportionately affected during the pandemic. Stories are being gathered through online self-submissions, facilitated opportunities to populate postcards and video interviews. Over 300 individual stories have been collected so far.

  All of the stories will be stored in the city's archives. A curated version of the stories will be exhibited in the millennium gallery in February 2023. A travelling 'community exhibit' and workshops will visit ten locations across the city. The narrative from all of the stories and experiences gathered from attendees at exhibitions will inform the city's central memorial garden.

During the pandemic I lost...

"

We lost our beloved dad and grandad, Leonard Gibson, who was the first person in Sheffield to officially lose his life to covid. He moved back to Sheffield from County Tyrone in his latter years, to be closer to family.

MICHELLE - WHARNCLIFFE SIDE, SHEFFIELD

"

When I think about the pandemic, it's hard to separate out the pandemic from the murder of George Floyd. And certainly for our community, the African Caribbean community in Sheffield, the two were very, very interrelated. And what struck me was the same conversation my father had with me, as a young black boy needing to try harder needing to be better, not expecting what other citizens from the white majority community took as as a right. I was having that conversation with my grandson. And that shook me. It was shocking. And it made me think we still, yes, there's been improvements. I will be the first to say there have been improvements, but we've still got a long way to go.

DAVID - SACMHA, SHEFFIELD

- *Community Grants***:** In August 2022, Compassionate Sheffield launched a community grants fund. The aim of this fund is to support community groups and organisations in Sheffield with grants of up to £2,000 to memorialise the Covid-19 pandemic. This will help to give people the time and space for reflection, acknowledging that the pandemic impacted everyone in different ways.

  68 applications have been received from a diverse range of communities with a good geographical spread across the city. The grants have been assessed and a panel will meet on September 26th to confirm the outcome of these applications.

  Approximately £80k will be awarded in community grants, with a further £20k held back to commission facilitated community memorial work with groups that did not engage with the grant application process.

  The activity of these communities will be captured and recorded as part of Sheffield's story. Additionally, Compassionate Sheffield's Community Development Workers will meet successful groups and work with them to encourage the values of Compassionate Sheffield, aiming to increase confidence around the context of end of life, death, bereavement, and loss.

- *Central Memorial*: The site of Balm Green has been acquired for the development of a central Covid memorial. SCC have committed to erect a sculpture of a tree by Covid Remembrance Day next year (March 23rd, 2023). The stories gathered from around the city will be used to inform the design of the memorial garden. Plans are under development that could see school children invited to design leaves for the tree on which some of Sheffield's messages from the pandemic could be inscribed.

5.1.4. Death is a Part of Life: Let's talk about it….

As part of Sheffield's Festival of Debate, Compassionate Sheffield partnered with Sheffield Hallam University's Lab4Living programme and hosted a programme of events that encouraged members of the public to come and talk about death.

The workshops were facilitated by activated citizens and used a creative structure combining the approach of Life Cafes (developed by Lab4Living, in partnership with Marie Curie) and Death Cafes (worldwide volunteer movement). The events were fully booked and 34 people attended the sessions, with 100% of people who evaluated the sessions saying they would come to a similar event again in the future.

One of Compassionate Sheffield's Community Development Workers is a trained End of Life Doula. They are working with members of the community to create safe space for people to talk about death. The aim is to provide sufficient confidence for attendees to facilitate their own conversations or workshops that encourage people to talk with confidence about death.

5.1.5. Compassionate Companions

At some point, everyone will interact with the end of life; knowing how to navigate this important part of life can be challenging. Equally staff, volunteers and members of communities supporting people approaching the end of their life, often don't know how to help.

Partnering with St Luke's Hospice, SCCCC, FaithStar and End of Life Doula UK, workshops are being delivered to staff and volunteers to help enhance their work in current roles. The workshops are focused on improving confidence to provide practical and person-centred support to people as they approach the end of their life.

Staff and volunteers naturally interact with people who are dying as part of their role, adding confidence to their compassion, and equipping them with extra, relevant knowledge will help them provide non-clinical support to the person who is dying. Topics of the three-day training being piloted in October 2022 include: will writing, grief, the dying process, navigating the care system, funeral planning, family dynamics and power of attorney.

After piloting the training, the ambition is to make information and learning available to anyone who wants to learn more, including members of the public from Spring 2023. The model has been adapted from a similar approach taken in Suffolk, with the project's partners we are working to ensure the offer matches the needs of people in Sheffield.

5.1.6. Death rituals and symbols: Community arts project

During the pandemic, people of Sheffield were distanced from the rituals and ceremonies that support the processing of death. Each community and individual has their own, unique relationship with death. These relationships are often played out through rituals and symbols.

Partnering with Ignite Imaginations, five different communities from across Sheffield are creating pieces of art. The artists facilitating this work will be a part of the community they are working with. The work will celebrate the different approaches to death, whilst using the topic of death to generate a sense of commonality.

After creating these individual pieces, the different groups will come together to showcase their work at the Millennium Gallery in early 2023. With the ambition of using the highly emotive and universal topic of death to connect across communities, differences can be explored, leading to a better understanding of inequity of experience across the city.

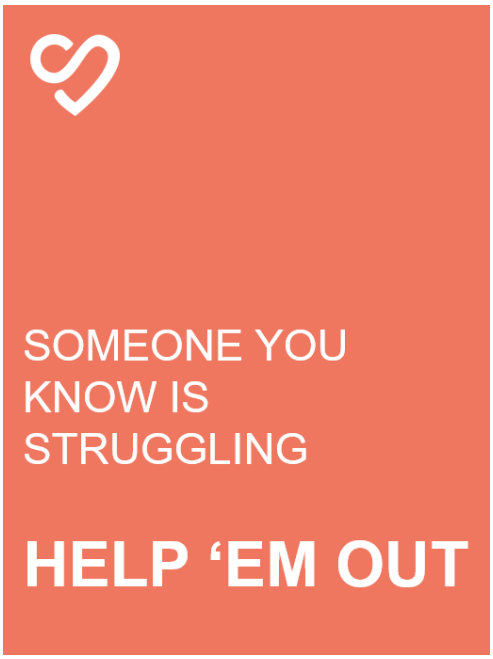
5.1.7. Warm Spaces and Welcoming Places

The values of compassion and the work of Compassionate Sheffield is not limited to the topic of death, dying, loss and bereavement. Over the winter of 2022/23 inequalities within the city will be further exposed and we are working to support the Warm Spaces and Welcome Places initiative.

Compassionate Sheffield's Community Development Workers will be present in community spaces and will deliver activities that aim to be fun and engaging and that bring people together. We plan to host movie showings, facilitate workshops, compassionate

conversations and other creative activities that encourage and inspire compassion within communities.

As well as delivering creative sessions, action-based messaging is being developed to inspire and encourage people to club together. Sheffield's communities are strong and its people, compassionate. Compassionate Sheffield aims to be an active partner and supports the city's Cost of Living Crisis Tactical Group.



5.2. End of Life Intelligence Workstream

5.2.1. Comprehensive record of service activity

Following the Health and Wellbeing Board support for the development of an integrated intelligence function, a partnership was brought together including representatives from commissioning and end-of-life care provider services, Public Health, both Sheffield Universities and national expert bodies to develop the Sheffield End-of-Life Intelligence Delivery and Advisory group with additional support coming from Compassionate Cities UK and Public Health England.

As with the Sheffield Compassionate City Project, the pandemic drew many partners away and progress was slower than had been hoped. That said, the group has assembled a large, quantitative dataset of deaths in hospital and the community and has successfully tested and applied locally-driven analytics, providing a more detailed exploration than national initiatives collating and publishing data on end-of-life care are currently able to provide.

This has realised the first stage in a longer-term ambition to undertake (local and Integrated Care Board) health needs assessments to better understand current, and predict future, end-of-life health and care needs.

6. Challenges

6.1. Compassionate City Project

6.1.1. Insecure funding

Compassionate Sheffield is a programme which in spite of being in its infancy is demonstrating that community-focussed, asset-based approaches are a feasible way of improving preparation for, and experience around the end-of-life. We know that such 'left-shift' is likely to offer sustainable, improved outcomes in the long term. Those outcomes are almost impossible to measure in the short-term, which has always been a challenge to commissioners.

However, such interventions are likely to be as cost-effective (if not more so) than traditional, medical interventions and may, indeed be cost-saving if taking a system-wide, long-term perspective.

These approaches do not come for free. To date, the partnership has received £463k (£207k excluding the Covid Memorial funding) in financial support – in the form of nine, discreet, ad hoc 'packages'.

This approach to funding does not give the programme the security and ability to plan even for the medium-term future, which is necessary to maximise its impact. It also takes staff time away from developing the programme, to make the case for packages of one-off funding – recurrently.

6.1.2. Limited capacity

The 'listen in order to learn, understand and empathise, then take appropriate action' interpretation of compassion can be shown to have a positive impact way beyond end-of-life situations.

Members of the Compassionate Sheffield partnership have been invited into conversations and asked to share methodologies with a broad range of events and settings: e.g. schools, dementia charities, reducing inequalities in primary care, homelessness, age-friendly city, SEND, HealthWatch, care home commissioning and transformation of large, public-sector organisations.

The potential to broaden the programme's scope and reach is limited by the small size of the team.

6.2. End of Life Intelligence Workstream

6.2.1. Ongoing resource

Whilst impressive to even national-level partners, the baseline dataset does not in itself help us to reduce inequalities at the end-of-life. Quantitative data alone cannot provide answers to essential questions beyond monitoring proxies of good end-of-life experiences

e.g. dying at home. If the system is to be transformed to ensure all have a good end-of-life experience, many other questions need to be answered. For example:

- How many people in Sheffield have a good death?
- Who gets a good death and is that fair?
- Could death be better if services were structured differently or if society viewed it differently?
- Can we make dying more cost-effective?
- What happens to those left behind after death?

Recent research has established that none of the current nationally available end-of-life care metric categories are able to compare the quality of end-of-life experiences for all people in all settings. In practical terms that means that if we in Sheffield want to answer those questions, we will have to do it ourselves. It is known that the only accurate way to understand if end-of-life experiences are good or bad is to combine qualitative with quantitative data.

By exploring and understanding inequalities in community and individual experience, service use, and needs, the Compassionate Sheffield programme can provide just such qualitative data in the form of stories, insights and community-based learning.

This can all, in turn be combined with socio-demographic, census and other public health data to examine trends, patterns and inequalities. This analysis will allow for a richer understanding of the end-of-life in Sheffield as experienced by individuals, neighbourhoods and communities. Only by understanding the differences between what people value at the end of life and the experiences they and the people around them have, can recommendations for action be developed, with potential to better support existing community assets and to replicate benefits of compassionate cities seen elsewhere in the UK and globally.

The potential for a truly intelligence-led approach is in reach, but does need analytical support to get there.

3.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE IN THIS AREA?

To maximise the impact of both the Compassionate City and Intelligence elements of this work – a sustainable approach to funding needs to be secured.

4.0 QUESTIONS FOR THE BOARD

- We ask the board to note the work that has been done in a relatively short period and challenging circumstances. Does the board agree that this work is an important foundation to achieve the ninth ambition of the H&WBS and as such, does it sponsor its continuation?
- Will the board agree to receive further updates in due course – after a period of sustainable funding?

- Can board members refresh individual organisational commitment to the integrated intelligence approach?

5.0 RECOMMENDATIONS

- We recommend that the H&WB board asks the Sheffield Joint Commissioning Committee if they will take this work forward as part of Sheffield's programme of integrated commissioning.

HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health, SCC
Date:	29th September 2022
Subject:	Sheffield Housing, Health and Wellbeing Summit – Final Report
Author of Report:	Greg Fell

Summary:

This report summarises the main points from the recent Housing, Health and Wellbeing summit sponsored by the board and proposes next steps for consideration.

Questions for the Health and Wellbeing Board:

The Health and Wellbeing Board are asked to reflect on the discussion described in the Summit report and on the proposed next steps.

Recommendations for the Health and Wellbeing Board:

The Health and Wellbeing Board are recommended to:

- Note the report of the Housing, Health and Wellbeing Summit and endorse its recommendations for next steps
- Provide feedback on the approach and operation of the Summit to feed into future work
- Agree to establish a time-limited task and finish group to identify appropriate resource to drive progress in this area

- Agree to receive a report from this group setting out how a programme of work based on (not limited to) the recommendations in the summary report will be established

Background Papers:

Appendix: Sheffield Housing, Health and Wellbeing Summit – Final Report

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Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

This issue relates to the ambition that **everyone has access to a home that supports their health**.

Who has contributed to this paper?

Janet Sharpe – Director of Housing, SCC

Juliann Hall – Care Health and Wellbeing Director, SYHA

Kathryn Robertshaw – Interim Director, Sheffield Health and Care Partnership

SHEFFIELD HOUSING, HEALTH AND WELLBEING SUMMIT – FINAL REPORT

1.0 CONTEXT FOR THE WORKSHOP

1.1 The Health and Wellbeing Board has had a number of conversations on the interaction between housing and health over recent years, but haven't to date done more than scratched the surface.

1.2 As part of a review of its ways of working, the Board agreed to shift its style of working and incorporate a number of mini conferences covering some of the wicked or tricky issues facing Sheffield, with the role of the Board being to sponsor and convene the conversation. The first of these focused on Housing and Health.

1.3 The context for the event is covered by three key points:

- **Quality of housing is linked to both length and quality of life:** it is established that housing (or lack of it, poor quality, other) is a determinant of the health of populations and individuals. There is a specific ambition in Sheffield's Health and Wellbeing Strategy to address this.
- **We know our strategy is "strategic" and there is a great deal of good delivery.** The workshop was held on the premise that one sector can't address complex multi-faceted problems on its own. As a city we already have lots of shared agenda, good partnerships and good joint delivery: our challenge is maintaining this, coordinating it better and building on it.
- **It is known that different sectors have different ways into the shared space of "health" and "housing"**, and see it differently. This means we need to actively bring people into that shared space to support better outcomes by building mutual understanding and partnership.

The aim of the workshop was to share understanding and experience of housing and health related issues, to set out a shared agenda across the NHS, social care and housing, and to capitalise on opportunities for better partnerships and joint delivery.

2.0 THE FORMAT OF THE WORKSHOP

2.1 The format of the meeting was a deliberate attempt to shift the style of conversation and to allow an in-depth discussion about a sprawling issue. What was obvious was that no one person or organisation actually "sees" the whole of a problem, and different sectors had a lot to learn about each other's style and ways of working. There was some acknowledged organisational self-interest within the discussion also.

2.2 Feedback to date from many stakeholders is that the format of the workshop worked well, enabled a wide-ranging discussion in a safe space and allowed people time and space to get into some detailed discussions. However there are concerns about a lack of diversity in the conversation, as well as a lack of lived experience and a tenant

perspective. There was also a desire to see the development of an action plan after the event.

2.3 Further feedback is welcome.

3.0 SUMMARY OF MAIN AREAS OF DISCUSSION AND RECOMMENDATIONS

3.1 The summary report of the workshop is appended and speaks for itself. The discussion centred on a number of themes:

- Health Improvement and access for families and people experiencing homelessness;
- Mental Health and Wellbeing;
- Living Well, Ageing Well;
- Housing and Primary Care Networks;
- Impact through Anchor Networks; and
- Housing and health and Community Investment.

3.2 Other themes that are no less important such as fall hazards in homes, cold homes and fuel poverty, or decarbonisation were not discussed.

3.3 **Thresholds for mental health support, and key working, was a topic of hot discussion.** Many articulated scenarios where residents might not meet a threshold for acute NHS support but where there is a definitive need for some support. Many described situations where professionals are carrying significant risks with insufficient expertise to manage those, also scenarios where there are residents with multiple problems (dual diagnosis within mental health), mental health and housing and no robust system to enable those needs to be met safely. The net effect of this is risk of people falling through gaps.

3.4 Many described a high level of reliance of Community organisations and the Voluntary, Community and Faith (VCF) sector more broadly. Whilst there is some good work already underway between Sheffield Health and Social Care NHS Foundation Trust and VCF organisations around supporting those on waiting list, the VCF sector is fragile at the moment and many articulated the need for investment.

3.5 Many participants articulated a desire to develop a mental health navigator or key worker role across health and housing (and beyond). This is in place in other places (for example Wakefield District Housing (WDH), where it is 50% funded by NHS and 50% by WDH to better support tenants with poor mental health, including within hospital support, addressing their housing context at the point of clinical assessment, identification of barriers at earlier stage, and unlocking help to get quicker discharge). Should the Board want to pursue this, there is good background work already done in Sheffield from some years ago. It was acknowledged that any key worker role should be someone with sufficient seniority to actually effect change.

3.6 The recommendations are within the main report but set out here:

- **Building housing into the Sheffield Health and Care Partnership (SHCP):** This should be at a strategic as well as at an operational level, working together to plan and deliver integrated services. The SHCP can also support the development of direct relationships between NHS providers and housing providers, identifying those areas that can be most impactful. As providers, they can collaborate to solve challenging issues and deliver improved pathway flow.
- **Integrating health and housing within the City Council:** the new Housing Strategy and Homelessness Prevention Strategy are opportunities to be more explicit about health and wellbeing and to define key actions that deliver on integration. The new Older People's Independent Living Strategy is also an opportunity for greater co-production and integration. Adult Social Care is developing a new operating model and have offered to integrate housing-based expertise at the neighbourhood level into their workforce. Those who are discharging people home, should look specifically at the home environment with the City Council and local housing associations. The quality of the Private Rented Sector (PRS) is a key issue.
- **Working together on the Cost-of-Living Crisis:** prevent further crisis, tenancy failure and breakdown and provide enhanced social protection. Develop joint work on mental wellbeing and mental health first aid
- **Working with local housing associations:** local housing associations are keen to take a greater leadership role in local collaborations, have access to capital and can more readily develop new provision. NHS estates planning across Sheffield should engage with housing associations to explore possible capital-based opportunities, with the GP Hubs, as well as when major estate programmes
- **Reinvigorate Sheffield Anchor mission and network:** Housing Associations are key anchors and like the NHS, the City Council, and the universities in Sheffield, have assets invested in the city for the long term. Aim to invest in building ongoing relationships where people learn more about each other and their organisations and the work they do. This needs to take into account issues outside of the direct delivery of services that all organisations are facing – workforce challenges, decarbonisation, economic and social development.
- **Learning from others and transferring the best opportunities to Sheffield:** West Yorkshire Health and Care Partnership provides an exciting example. This work started in Wakefield, sponsored by the Health and Wellbeing Board, before being transferred to the whole West Yorkshire Integrated Care System (ICS). A work programme was established for Wakefield, that then transformed into a work programme for the ICS. The London Borough of Southwark also provides another example. Southwark has a similar set-up to Sheffield.
- **Creating space for creative conversations and partnership development:** All participants at the Summit spoke about how important it is to have the space and opportunity to meet, learn about each other, explore current challenges, and identify opportunities for future joint working. What is needed are the mechanisms

for people to start working together, and the development of a housing and health work plan.

4.0 NEXT STEPS

4.1 The report, recommendations and discussions can readily form the basis of a programme of shared work across sectors with some specific tactical and strategic projects across the sectors. That would readily link to the 5th ambition within the Health and Well Being Strategy. Such a programme needs to build on networks and partnerships we already have.

4.2 There is much that can be learned from other areas – Wakefield, West Yorkshire and Southwark are name checked in the report. The programme in West Yorkshire started in Wakefield and has since been expanded. There is effort to ensure housing professionals are part of relevant NHS mechanisms and groupings, and vice versa. There is also an explicit plan to ensure operational and strategic links are the norm, with some programmes reliant on specific bids for funding and some programmes based on existing mainstream resource.

4.3 Success does rely on a person to be the focal point for the housing and health plan. The work in Wakefield and then West Yorkshire work started with the secondment of a lead officer into the then Clinical Commissioning Group to integrate the housing system into NHS infrastructures.

5.0 QUESTIONS FOR THE BOARD

5.1 The Health and Wellbeing Board are asked to reflect on the discussion described in the Summit report and on the proposed next steps.

6.0 RECOMMENDATIONS

6.1 The Health and Wellbeing Board are recommended to:

- Note the report of the Housing, Health and Wellbeing Summit and endorse its recommendations for next steps
- Provide feedback on the approach and operation of the Summit to feed into future work
- Agree to establish a time-limited task and finish group to identify appropriate resource to drive progress in this area
- Agree to receive a report from this group setting out how a programme of work based on (not limited to) the recommendations in the summary report will be established

Sheffield Housing, Health and Wellbeing Summit

Final Report

Andrew van Doorn

September 2022

Contents

1. Background

The last two years have been an extraordinary time for the people and communities of Sheffield, their City Council, and the NHS. The Covid pandemic has thrown into sharp focus the health and wider inequalities that exist throughout our communities and tested the design, effectiveness, and resilience of our community response. Whilst the City Council and the NHS have been at the centre of the planned response, the role and contribution of housing has also come to the fore.

New relationships and partnerships have been built at speed and existing community-based collaboration, such as Age Better Sheffield, have mobilised much needed support to keep people safe and well in the community. Our homes have never felt so important. Overnight they became the places where we live, school, work and stay safe. But for some, they were also places that heightened their isolation, where they felt trapped, and worsened their health and wellbeing.

Moving out of a period of significant restrictions due to Covid has come as a relief to many. However, this relief feels short-lived as we now find ourselves in a cost-of-living crisis and the NHS and social care are facing unprecedented pressures. The resilience of our communities and organisations is once again being severely tested

Housing associations and housing support providers across the city have and continue to play a major role in the City's response. They have the potential to play an even more important role in the years ahead as the people of Sheffield respond to the cost-of-living crisis by building on the new relationships and partnerships that they have developed.

Leaders within the Health and Wellbeing Board, and their partners in the Sheffield Health and Care Partnership, recognised that further action is needed to integrate housing within the health and wellbeing agendas across the City Council. They wanted to explore with their local stakeholders how a more central role for housing could be built and delivered in their future plans.

A Sheffield Housing, Health and Wellbeing Summit was established to bring these senior stakeholders together to begin exploring areas for shared opportunity and action. This report details the outcomes of the Summit and suggests potential areas for future action.

2. Sheffield Housing, Health, and Wellbeing Summit

The Housing, Health and Wellbeing Summit provided a platform to explore and take forward collaboration between key stakeholders in the City. It was hosted by the Joint Health and Wellbeing Board and the Sheffield Health and Care Partnership (SHCP).

The aims of the Summit were to:

- Build an enhanced understanding of the importance of housing for achieving the health and wellbeing outcomes for the people of Sheffield.
- Explore the opportunities for greater collaboration and integration of housing in the delivery of health and wellbeing programmes and services.

- Explore the potential of housing associations and SHCP working together as anchor institutions.
- Identify key actions and priorities for taking the outcomes of the Summit forward.

The Summit involved around 40 key stakeholders and leaders from across the city (see Appendix 1 for invitees). Attendees brought their professional and lived experiences to the Summit and where appropriate, were asked to commit their organisations to delivering the Summit's outcomes.

The Summit was facilitated by Andrew van Doorn, Chief Executive, HACT, with support from a small steering group involving the City Council, SHCP and South Yorkshire Housing Association (SYHA).

3. Strategic environment

The Summit was designed to build up and enhance the strategic environment for housing, health and wellbeing in the City. The Sheffield Joint Health and Wellbeing Strategy lays the critical foundation for a strong connection with housing, with an ambition that:

'Everyone has access to a home that supports their health'.

It recognises the need for more affordable homes to be built for local people, the value of the investment in home improvements to release the associated savings to the NHS in Sheffield of around £5.4m, and action to address homelessness[1].

The Sheffield Housing Strategy[2] and Homelessness Prevention Strategy[3] are both due to be renewed. They recognise the importance of health and wellbeing in their plans, as well as the relationships needed between the City Council and their local health partners to deliver them. In 2015 to demonstrate its commitment to tackling the health conditions of people who experience homelessness, Sheffield signed up to the Homeless Health Charter[4].

Significant changes have been taking place in the strategic health and social care landscape, with the creation of the South Yorkshire Integrated Care System. New legislation put this onto a statutory footing from July 2022, with the powers of the Integrated Care Board being confirmed in law.

The Sheffield Health and Care Partnership is the place-based partnership that drives forward collaboration and integration in the city. It's vision for 2030 is moving from collaboration to integration, tackling inequalities, and putting people at the heart of their vision[5].

It recognises a closer connection with a range of community and local government services and resources, including social care, housing, and the voluntary and community sector. It

[1] https://democracy.sheffield.gov.uk/documents/s34751/Joint%20Health%20Wellbeing%20Strategy%202019-24.pdf
[2] https://www.sheffield.gov.uk/content/dam/sheffield/docs/housing/housing-strategy/housing-strategy-2013-2023.pdf
[3] https://democracy.sheffield.gov.uk/documents/s29089/Homelessness%20Prevention%20Strategy%203.pdf
[4] https://www.sheffieldccg.nhs.uk/news/Health-and-Wellbeing-Board-Signs-up-to-Homeless-Health-Charter.htm
[5] https://www.sheffieldhcp.org.uk/content/uploads/2021/11/3.2.pdf

sees the VCS as a key partner and as a disrupter, with a key role in expanded primary care, providing health and care services with a wider perspective, and playing a role in developing the economic and social capital of the city. With their partners, the SHCP wants to unlock the role of their partners as anchor institutions.

Finally, the housing associations working across the South Yorkshire Mayoral Combined Authority outlined in their February 2002 Housing Prospectus, the importance of housing and health.[6] As one of five offers outlining their long-term commitment to the communities in South Yorkshire, they recognised how housing is a cornerstone to the wellbeing and prosperity of individuals and families. Their considerable role in supported housing, accessible housing, community investment, homelessness support and social and affordable housing, will see them working with the NHS and local authorities to close the gaps in health and mental health.

4. What participants wanted to achieve

The Summit started by exploring what participants wanted to achieve. Conversations about expectations often reveal a range of motivations, as well as ambitions, challenges, successes, key enablers and where to focus. There were a huge number of contributions, demonstrating the clear intent to work more creatively together. The key themes have been captured below.

Increasing understanding – for many people, increasing understanding of each other and how they can work together was a key ambition for the Summit. There were many areas where greater collective understanding is needed between housing, health and social care, and people were keen to identify the issues, what does and doesn't work, how funding could work, and learn more about the system. There was interest in where power and influence lies, what are the blocks to the goals that are shared, and how different stakeholders need to listen, learn, and deepen understanding.

Explore and emphasise the importance of co-production as part of the solution - understanding how we can work with citizens and their ideas and assets was a key issue for many. It was noted that there were important perspectives missing from the Summit and that any solutions need to be co-produced with the people of Sheffield.

Participants wanted the Summit and to be **creative, collaborative, and connected**, so they could **share ideas and solutions, be inspired, be challenged, and be different**.

People wanted to **develop new partnerships**, however they also asked how welcoming Sheffield is of new partners? They recognised that organisations need to work on how they can be better at being good partners. This included exploring what skills, expertise, structures and culture/behaviours leaders needed to drive this forward. A key issue was to work on how partnerships and their ideas become sustainable.

It was important for participants to **explore their leadership and what contributions they can make.** They wanted to do this as an NHS provider, a housing provider, and from existing collaborations such as the South Yorkshire Housing Partnership. Looking at the culture of leadership with a willingness to be collaborative and 'let go, and being honest about what is and isn't working, were important.

[6] https://www.yorkshirehousing.co.uk/media/SYHP-Prospectus-Feb-2022.pdf

How can we work more closely at the Neighbourhood level - the '20-minute city' is a key concept that participants were keen to explore, having all services close by to support the community. The importance of green spaces was raised.

There was a recognition that particular groups needed attention and focus. These included people living with mental illness and learning disabilities and autism, the frail elderly, people living in the PRS, and people with complex needs.

How do we deliver integration between health, housing and social care more strategically? Participants wanted to focus on aligning the Sheffield City Strategy, with the Sheffield Health and Care Partnership Strategy, the new housing strategy and the homelessness prevention strategy. They also wanted to explore how health and housing fits into the broader system of 'economic wellbeing' and how to 'bake in' housing to the new health governance partnership structures, at the Sheffield Health and Care Partnership and South Yorkshire ICS.

Improving integration to deliver impact - participants identified that they needed to address silo budgets, agree where resources can make the most impact, agree a small number of specific actions now and in the long term, and identify the measurable goals and objectives. A key outcome of the discussions and summit should be to identify the tangible opportunities and create simple ways for housing and health services to interact more successfully.

Finally, people want there to **be services in Sheffield that everyone can be proud** of and to do this there **needs to be action**. They were keen to hear something about how we are going to move forward after the Summit.

5. Setting the scene

The Summit heard from a number of strategic leaders in the City, identifying the issues that need to be addressed.

We opened with newly elected **Mayor of the South Yorkshire Mayoral Combined Authority (MCA) Oliver Coppard**. He spoke about the need to keep this personal as our homes and our health matter to all of us. There are many issues facing the communities of South Yorkshire and no one organisation or sector can address the multi-faceted issues that we face. Whilst the Mayor can work at the South Yorkshire level, and make the case to Government for investment, policy innovations start local.

The economy is in service to the people, the planet and the wellbeing of our communities. South Yorkshire has been an important economic engine, built on major industries. There have been major changes over generations and his role is to deliver on the economic development needed for South Yorkshire. 2030 is not so far away, if we put ourselves there what do we need to be doing now to deliver on our ambitions?

Cllr Angela Argenzio, Co-Chair of the Adult Health and Social Care Committee at Sheffield City Council, spoke about the importance of partnerships and the role that the Council plays in co-ordinating different partners. She spoke passionately about the importance of the home and what makes us feel secure. She also emphasised the relationship between the home environment and good health. The Health and Wellbeing

Strategy is clear that “Everyone in Sheffield should have access to a home that supports their health”.

As a Ward Councilor, her casework inbox is full of people who are ill because they live in a house that is unsuitable. This has significant implications for both physical and mental health. She recognised that cost-of-living issues, such as fuel poverty, is driving people to make difficult choices that will have an impact on cold related illnesses, and more cold weather deaths. Providing secure and affordable housing has a huge cost savings, including for the NHS, but it is more than just providing a house, it’s also about the wraparound services and support that makes a house a home.

Kathryn Robertshaw, Director, Sheffield Health and Care Partnership outlined the history of the Health and Care Partnership, originating from the Accountable Care Partnership formed at the end of 2017. This brought together the health and care providers and commissioners in the city and developed the *Shaping Sheffield* (Our plan for 'Shaping Sheffield’)

This plan has three key strands: 1) tackling health inequalities, 2) integrating services, 3) putting people at the heart of what we do. The South Yorkshire Integrated Care Board (ICS) will be established from 1st July 2022, replacing the four Clinical Commissioning Groups across South Yorkshire. In addition to this, there has been a big change in how Sheffield City Council works through the move to a committee-based structure. The consequence is that how decisions are made about how health and care is commissioned across Sheffield is changing.

The development of new partnerships means changes, with the shift to focusing on early intervention and prevention as a key part of the plan. There is also critical work needed to integrate care in and out of hospitals. All of this means that there is a good opportunity to build new relationships and finally bring housing into those conversations.

Janet Sharpe, Director of Housing, Sheffield City Council outlined the important role that the City Council plays as the largest landlord in the city (c40,000 homes). Previously Sheffield had some of the lowest levels of homelessness, but this has increased in recent years. Housing in the city is not meeting needs, and there is overcrowding, domestic abuse, and uncertainty over the private rented sector (PRS) in the city. The distribution of tenures in Sheffield are: 59% owner occupied, 25% social housing (18% council and 7% housing association), 16% private rented.

The PRS is due to double in the next 10 years and as there is significant demand for housing there is an opportunity to work more with housing association partners. There are clearly not enough affordable homes with 2,000 bids per week on 70 homes for re-letting. Prolonged stays in emergency accommodation have major impact on health (approx. 500 currently). People with disabilities are struggling to find homes to meet their needs.

The new housing strategy will have to look at how to increase supply and the variety of homes. It will also need to look at how to improve warmth in housing, and to reduce hospital admissions. Currently 30% of private rented housing in the city has a hazard.

Tony Stacey, CEO SYHA, emphasised that social housing resulted from a public health crisis in Victorian England, so the connection between housing and health has always been important. There were many similar experiences during the pandemic, and we recognised more clearly that homes are where people reach the end of their lives, and where their health deteriorates. Providers of housing therefore have had to rethink how they operate.

Unfortunately, his experience is that housing is not getting a seat at the table. There is a need to remove artificial barriers. Integration is mainly talked about in terms of health and social care, whereas housing is the third leg of the stool. There is a need to work on integration across health, housing, and social care.

The priorities for organisations like South Yorkshire Housing Association moving forward are on decarbonisation – how to retrofit homes in the absence of sufficient Govt funding (funding £3.4bn, cost £104bn); poverty and the impact this has on people and communities; and homelessness with increasing challenges of its growth in Sheffield, and elsewhere.

He urged the Summit to utilise the ' burning platforms' of the cost-of-living crisis, retrofitting, and housing inequalities, to be courageous in collaboration and creating the solutions needed. Housing Associations are key stakeholders and can work together to co-design solutions with adult social care and health.

The resulting discussion following the scene-setting identified several issues and opportunities:

- Decarbonisation is an issue for housing, NHS, social care and local government (as is the workforce challenge) – collaboration between partners can look beyond just service delivery
- Need to uncomplicate systems, to get back to what matters to people in communities
- Need action-driven conversations
- Urgent emergency care domain – board disbanded during Covid. Why not get housing round the table to bring new perspectives and new solutions?
- Private sector conditions – owner occupied and private rented, fuel poverty at 46% across the sector
- Don't just think of housing as a discharge place for hospital patients.
- Child poverty is a big issue: if a child is in poverty so is the family
- Need to ensure the diversity of Sheffield and bring broad perspectives to the table
- Citizens have ideas as well as problems. Need to see them as assets not problems.
- Limited understanding between sectors, what do we know about each other?
- Individual orgs have problems, what can we do to help each other solve them, i.e. surge wards

6. Workshops

The Summit explored a range of different opportunities through facilitated workshops. Key highlights from these workshops are outlined below.

6.1 Health Improvement and access for families and people experiencing homelessness

Homelessness is a significant issue for every local authority in the country. In the past Sheffield has led the way in addressing the health needs of people who experience homelessness. This workshop looked at what more needs to be done to ensure that those people who experience the worst housing distress get access to the health care and support that they need. What can housing, health and social care partners do to ensure that the duty to refer is effective, and people with No Fixed Abode are not stranded in NHS services.

There is some good collaborative working in the city around homelessness where we are trying to look at the individual as a whole and not be too service based. However, there are not enough resources to meet need. Good partnership working can leverage in national resources, such as specialist employment advice.

Safeguarding partnerships have been established around substance abuse and mental health. But to prevent crisis we need to commission differently, and look at how we work with those when in crisis? Inequalities are growing and this is exacerbated in access to services, for those with complex needs, and increasing the costs of being unwell. Services are often difficult to access, unless there is a crisis which raises the question of how we can take interventions and support more upstream.

Sheffield has a Changing Futures programme where individuals with lived experience are being heard and are having an input. This is shaping multi-agency and local responses and is a good model that could be replicated.

Housing associations are changing the way that housing and health works, mapping the gaps in health and how their service fit. They have found that residents will talk to them so these relationships can be utilised to get access to customers who other professionals find difficult to reach.

West Yorkshire Health and Care Partnership is a year ahead in housing and health partnerships and this is an opportunity to be grabbed. There are conversations taking place through existing partnerships in Sheffield, but more conversations are needed with all partners.

What do we need to be working on?

- October energy price cap rise will be the health and homelessness crisis of the future – those who have not engaged before will start presenting. Families are already presenting with significant challenges. Can we focus now on preparing for this and doing more on prevention? How can our staff be prepared to support families?
- Covid was a long-term event we hadn't planned for, but we responded quickly. Cost-of-living is a long-term crisis that we know will be getting worse, so we can use the learning from Covid. We have 3 months before next stage of cost of living worsens so use that time to prepare.
- This is the first time we have got everyone in the room, we should build on this.
- Can we invest in mental health professionals within services – huge delay to get to them and we need to make access easier.
- Need to look at workplaces and how frontline staff are supported, they will hear and see the worst of the impacts.
- Opportunity for change – more insight now, not just Sheffield but the South Yorkshire Mayoral Combined Authority level

6.2 Mental Health and Wellbeing

Sheffield has been at the forefront of pioneering housing-based solutions for people with severe mental illness. They are seen as a national exemplar in addressing the high cost of out of area placements. This workshop explored what more can Sheffield do to deliver recovery and housing outcomes for people living with long-term mental health issues. As a result of the pandemic, we have also seen an explosion in common mental health issues (e.g., depression and anxiety) and mental wellbeing is a key issue. How can housing providers work with local health and social care partners to identify and support people in the community?

Sheffield is often held up as a national exemplar for putting mental health placements within the city. People often talk about the 'Sheffield Model' in delivering an integrated health, housing and care approach for people living with long-term mental health problems. But we are struggling now.

Our biggest challenges are how we come together for complex cases to stop the cycle of poor mental health and housing breakdown; and how we expand services and work in a trauma informed way to meet the massively growing demand. With limited resources it is even more important to work in partnership, but all partners are struggling with resource and lack capacity to engage and transform.

There is a need to get the right services to people who are presenting in crisis. This must include housing as there is not the right accommodation available. There are also those who don't present and are staying quiet that we need to be worried about. We need to ensure that we are reaching people that live alone, don't have any support, that are ageing, and maybe very isolated.

Practical and pragmatic things we can do:

- Sign posting - reiterate the contacts we have and services we offer, what they do and where they can be accessed.
- Changing Futures programme which is targeting complex individual cases - need to look at sustainability of this. All our organisations sit on the board so we should carve something out between us to collaborate better and share information.
- Build on existing assets, supporting staff, supporting our community assets, learning from food banks where people are open to having a conversation in a safe space where they don't feel judged.
- Think about how we provide wrap around support.
- Influence priorities in the system, e.g. prioritise mental health and physical health parity. The ICS priorities show this is not the case even at a high level.
- Develop good practise in service delivery that looks at mental health inequality impact assessments.
- Hold conversations around substance misuse and explore how to engage with people.
- Really need to consider staff wellbeing at the moment. We need to have honest expectations of them and look after them as the media spotlight is on our services and people are suffering from stress and burnout - and it will get worse.

6.3 Living Well, Ageing Well

This workshop focused on specialist and supported housing, for people of working age and older people. It looked at how can partners can work together to deliver a vibrant and integrated supported housing and health environment. How can the transformation of health and social care pathways locally deliver more integrated supported housing?

Together, members of the workshop were interested in looking at how older people are treated as citizens, not just service users. It is important to work with older people in a more holistic way, using asset- based approaches to engage and deliver outcomes. We need to ask what people want for themselves and ensure that all older people have a voice.

Integration is an interesting term and it is important that together we explore what this means. A more integrated future needs to actively address inequalities and be clear about how we meet the needs of different communities and deliver more equitable access to

services and support. We also need to articulate what the future holds for Sheffield residents.

We want to build on what works and share knowledge across all partners and all sectors. We need to be clear about where different people, their expertise and organisations can add value.

If we had a Magic Wand, we would:

- Work together to deliver services and support to enable pride and dignity.
- Get the right parts of the system to speak to each other and be equipped to have honest conversations and explore in more depth how we achieve aspirations with people and with partners.
- Get people the right help at the right stage/right place, shifting our focus and resources from crisis to prevention.
- Have an agreed position on how we meet the shortfall in funding together? And also secure longer-term funding and the future of integrated services.
- Create a shared vision to harness energy from the city to respond collectively to housing and health - articulate to government.
- Have a greater contribution from private sector to their city, e.g. collaboration on older people's housing strategy.

6.4 Housing and Primary Care Networks

PCNs are an important building block for integrated care in the community. This workshop looked at how PCNs can work with local housing providers to improve primary care outcomes. There are some excellent Social Prescribing services delivered by housing providers locally, as well multi-agency programmes focusing on supporting older people. How can the emerging PCNs and the investment going in around social prescribing, community pharmacy, community paramedics, and mental health support, interface and be enhanced by a relationship with housing.

GPs experience a range of issues in relation to housing in their everyday practice. They are concerned about mental health and stress related illnesses that are caused by the condition of housing, homelessness and rehousing, sofa surfing, and poor lifestyle. Whilst concerned they also lack the ability to help. Physical health conditions are also a concern, particularly the prevalence of COPD, caused or made worse due to damp and moldy housing (although patients don't necessarily make the connection to housing).

Infections and infestations are also a feature and GPs are seeing conditions they thought were a thing of the past. This is often linked to overcrowding. Modern slavery and trafficking are also in the City and is linked to overcrowding (although a lot more hidden).

The City Council Housing employs a Housing+ Model. Patch officers have holistic conversation with tenants annually, including things like whether people are registered with GPs, living conditions, health conditions. From this, they have found that 70% of tenants have no need, 30% have "some need" and a small percentage, circa 5%, have "constant" need.

The main concern of those working in housing are around how to get the right support in place and with the right housing. The City Council has a duty of care to individuals and the community and Housing+ makes 6,000 referrals a year. However, thresholds for care and support have increased which is perhaps the biggest challenge.

What are the issues we need to be working on?

- People are being moved into general needs housing who are unable to live independently due to a lack of supported housing. Addictions and mental health are currently especially difficult.
- Support doesn't always follow through in the community. NHS Trusts are focused on the patient and not community. Treatment and supported housing are needed but people need to present with significant risk issues to access secondary care.
- Mental health transformation work aims to get to a better place – cultural change is needed. Treatment is the focus, but housing is not seen as part of the solution.
- How are personal safety issues of patients risk assessed? People get passed around and issues sometimes present as a housing problem but are more complex with multiple services involved with no-one owning the problem (or solution). Fragmented services mean that often housing or the police are left holding the ring. Where there is support, such as from social landlords, this doesn't extend to other forms of housing.
- How do we remove the obstacles from the system?
- Keyworking approach has the potential to reopen and reinvigorate and to create a preventative city. This could be linked to PCN teams, but need to address practical stuff around making connections and issues of data sharing
- We need, but don't have, one system to join things up across services and professionals. What can we get behind?

6.5 Impact through Anchor Networks

The fourth objective of an ICS is to contribute to social and economic development. The NHS and their partners in local government are exploring what it means to be an anchor institution. Housing associations are also anchor institutions and are rarely engaged in anchor networks. This workshop looked at what the ambition is for Sheffield, with the City Council, NHS, universities and housing, to unlock the potential of anchor institutions to invest in Sheffield and deliver sustainable community wealth-building outcomes.

It was recognised that Sheffield doesn't always build on what works well and capitalise on what is happening in communities. There is a feeling that the City Council often goes to the same people, groups, and networks for solutions. It is important that in taking forward work around Anchors that we include community anchors, and not just large public sector bodies.

There is a key question on how to manage the challenge of co-ordinating large complex organisations in the city? This requires leadership at all levels. It will be important to understand the scale of the potential impact if we invest locally and what can be achieved if a community wealth building approach is developed.

An Anchor Mission for Sheffield needs focus and specificity and a clear part of this is identifying where community anchors can add value. Financial stability (or lack of it) can be a real barrier to engagement for some organisations.

It is worth exploring what anchors can commit to doing together. Such as working on issues of local employment, using commissioning and procurement policies to drive social value, understanding and working on the environmental impacts and allowing access to local services that encourage the 20-minute neighbourhood.

Our top priorities for moving forward are:

- Re-ignite the anchor work with mid-level manager specificity and leadership.
- We need sustained, high quality leadership, communication, openness, honesty, and transparency to take this agenda forward. Cost-of-living crisis gives us urgency to act.

6.6 Housing and health and Community Investment

Community Investment is a significant aspect of the work of local housing associations. Health inequalities have come to the fore over the pandemic and many housing associations have delivered enhanced community-based services in support of their tenants and communities. We wanted to explore what more can be done to sustain new relationships and unlock community-based resources and reach that housing associations have. What new ideas and partnerships are needed to bring housing into a more central role to address health inequalities and population health?

Housing Associations across England invest around £750m per year in their communities, this is known as Community Investment[7]. It involves community-based programmes such as: employment, education and training support (e.g. IKEA recruitment); community development and regeneration; advice and guidance to help get people closer to services; anti-poverty and financial inclusion services; support for younger people and older people; and health and wellbeing programmes. This is targeted at tenants as well as the wider community.

This is work primarily delivered by housing associations, whereas SCC has a Housing+ approach, which is focused on annual visits where an holistic conversation takes place and referrals are made to local services. This is aimed at tenants and households. SCC also supports Tenants and Residents Associations (TARAs), but they acknowledge not everyone wants to be part of TARAs. They also work with existing social networks.

Adult Social Care will have staff working in housing patches so connections made at a senior level should be made at the ground level too. How can we make this happen and enable people to access all local resources? We know that joined up solutions can add value and there are opportunities to explore how we value social capital and community organisations, and link this and the community investment work to health inequalities

Next steps and suggestions:

- Sharing data and local intelligence – better sharing to understand unmet need and could identify those people who are not reactive to contact, but could be at risk
- There are trust issues that need to be recognised, so trusted intermediaries could help.
- There is a huge breadth of linkages that need to be made at the neighbourhood level, we need a system to support and create these linkages.
- There could be an offer from Adult Social Care, who are developing a new operating model in social care – they can bring this into conversation about how to work at neighbourhood level.
- There could also be an offer to run a joint pilot for health initiatives through existing networks and pilot it on silent customers. This would involve sharing intelligence and making connections.
- Could also look at mapping all local services as part of social prescribing.

[7] For more information visit the Centre for Excellence in Community Investment – www.ceci.org.uk

7. Where can we have most impact together

Discussion held throughout the Summit identified several opportunities where, by working more creatively together, housing, health and social care partners could have considerable impact.

7.1 Building housing into the Sheffield Health and Care Partnership

The Sheffield Health and Care Partnership provides an opportunity for new relationships to form and be established. It was recognised that housing providers, both the City and local housing associations, could be more involved in the partnership and working together to plan and deliver integrated services. The SHCP can also support the development of direct relationships between NHS providers and housing providers, identifying those areas that can be most impactful. As providers, they can collaborate to solve challenging issues and deliver improved pathway flow.

Urgent and Emergency Care is under significant pressure and housing providers' resources and expertise can be better integrated and deployed within the plans going into winter and beyond. In the future there is potential for a health and housing plan to be developed and owned by the SHCP with some key actions and accountability for its delivery. Housing workstreams have been developed in other ICS areas, such as West Yorkshire, and this could be replicated in Sheffield and its wider ICS.

7.2 Integrating health and housing within the City Council

The development of the new Housing Strategy and Homelessness Prevention Strategy are opportunities to be more explicit about health and wellbeing and to define key actions that deliver on integration. The City Council has already followed up to invite engagement and participation from health and wellbeing partners in the development of the Homelessness Prevention Strategy. Similarly, the new Older People's Independent Living Strategy is an opportunity for greater co-production and integration.

Adult Social Care is developing a new operating model and have offered to integrate housing-based expertise at the neighbourhood level into their workforce and support model. This needs to go beyond the local authority housing support offer (Housing+) and embrace the tenancy support and community investment work of local HAs. This initiative could spearhead work to share greater community-based intelligence, better co-ordinating neighbourhood level support that is integrating housing with the PCNs.

Quality of the PRS continues to be a key concern and there are negative health outcomes when the home environment is poor and dangerous. Falls and trips, damp and mould, and cold homes needs to be addressed. Partners who are taking forward the NHS ambition for developing Virtual Wards, and those who are discharging people home, should look specifically at the home environment with the City Council and local housing associations.

7.3 Working together on the Cost-of-Living Crisis

There is urgency to work collaboratively on the cost-of-living crisis, and how it will begin to worsen from October. This is a key opportunity to prevent further crisis, tenancy failure and breakdown and provide enhanced social protection to the citizens of Sheffield. The assets of citizens and their engagement needs to be part of the solution.

The City council and its partners are already working on a citywide response.[8] .This is built on the collaborations and partnerships created throughout the pandemic. A Cost-of-Living Strategy Group has been established and had its first meeting the same week as the Summit. The Group has agreed a strategy and action plan which will be continuously updated.[9]

Sheffield partners have can work collaboratively to build resilience of its frontline workforce across all services (council, housing, health), this could include joint work on mental wellbeing and mental health first aid. This will be even more critical as we move forward and people experience working with those experiencing greater distress.

7.4 Working with local housing associations

Whilst Sheffield City Council is the main social landlord there are also local housing associations who are keen to take a greater leadership role in local collaborations. Housing Associations have easier access to capital and can more readily develop new provision. They also have more evolved community investment responses that deliver support and open opportunities for local people.

Whilst the public sector, particularly the NHS, is often constrained when it comes to capital, this is less so for housing associations. NHS estates planning across Sheffield should engage with housing associations to explore possible capital-based opportunities, with the GP Hubs, as well as when major estate programmes such as the Fulwood HQ for Sheffield Health and Social Care Trust. Being creative with the estate can bring forward affordable housing for local people and health and social care staff, as well as unlock social value for the local community. Housing associations need to be part of the conversations early on and the City Council needs to use its planning obligations to drive this forward.

Issues of revenue are key when stimulating the supported and specialist housing market locally. We have already seen what is possible when creative partnerships are developed between the NHS and housing associations in the city, that create new independent living solutions for people who would otherwise be stuck in costly out of area NHS placements.

The South Yorkshire Housing Partnership is keen to work directly with health partners, at system and place levels and this should be taken forward at pace as new strategies are developed and agreed.

[8] https://democracy.sheffield.gov.uk/documents/s53206/5%20-%20Cost%20of%20Living%20Crisis%20SR%20Committee%20paper%2005.07.22.pdf
[9] https://democracy.sheffield.gov.uk/documents/s53206/5%20-%20Cost%20of%20Living%20Crisis%20SR%20Committee%20paper%2005.07.22.pdf

7.5 Reinvigorate Sheffield Anchor mission and network

Anchor missions and networks need to be reinvigorated and should include all anchors in the city. Housing Associations are key anchors and like the NHS, the City Council, and the universities in Sheffield, have assets invested in the city for the long term. Together they can align their strategies and work with citizens locally to have long-term and sustainable impact.

To do this, partners in Sheffield need to invest in building ongoing relationships where people learn more about each other and their organisations, and everyone feels they are valued and have a role to play.

There are also issues outside of the direct delivery of services that all organisations are facing – workforce challenges, decarbonisation, economic and social development – where, by working together as Anchors, partners could have greater impact. A more vibrant Anchor Network could create space for these connections and conversations to happen.

Across all public bodies, including housing associations, Social Value is a key opportunity for driving collaborative and impact change. There could be considerable value in aligning social value asks within procurement now that the NHS is scoring social value with a 10% weighting across procurement since April this year.

7.6 Learning from others and transferring the best opportunities to Sheffield.

Sheffield has the opportunity to learn from other areas about how they are moving forward with integrating housing, health and social care at both a Place and a System level. West Yorkshire Health and Care Partnership provides an exciting example of how a focus on housing can be influential in building partnerships and delivering improved health and housing outcomes. This work started in Wakefield, sponsored by the Health and Wellbeing Board, before being transferred to the whole ICS. Central to the approach was the secondment of a director from the local housing association to the then CCG, to lead the development of collaborative working.

From this a work programme was established for Wakefield, that then transformed into a work programme for the ICS. Having dedicated leadership that can represent the opportunity of housing in the wider workstreams of the place-based partnership, and a clear work plan have been really impactful.

The London Borough of Southwark also provides another example. Southwark has a similar set-up to Sheffield, in as much as they are the main social landlord locally and work through tenants and residents associations. There is also a vibrant housing association sector locally who run major community investment programmes in the borough and across London. Strategic Housing colleagues in Southwark asked their Public Health Team to support them in developing a specific part of the Housing Strategy around health. To do this, HACT supported them to develop a local partnership with housing associations to explore and align their public health priorities with the community investment activity taking place.

This work was mainly done pre-pandemic and proved impactful in co-ordinating the community response when they went into lockdown. The key to this was the opportunity for social landlords to share their existing community health and wellbeing programmes, share opportunities to collaborate, identify gaps and align this with wider council and health priorities.

Finally, partnerships in East London, Liverpool, Birmingham, and Walsall have been working together around the shared workforce challenge. Housing associations deliver significant education, training, and employment programmes for their residents. Directing these at NHS and social care jobs can be impactful and contribute to addressing the health inequalities faced in social housing communities.

7.7 Creating space for creative conversations and partnership development

The final area of impact is more about the how, rather than the what. All participants at the Summit spoke about how important it is to have the space and opportunity to meet, learn about each other, explore current challenges, and identify opportunities for future joint working. These spaces already exist and are often curated around specific issues, client groups, services, or programmes. They are valuable spaces, and perhaps more can be done to use them to drive forward new ideas and a greater shared purpose.

There was a clear call from some that no more strategies are needed (well at least no more than are already in the plan). What is needed are the mechanisms for people to start working together. The development of a housing and health work plan within the HSCP could be beneficial, but perhaps more so would be a particular member of staff who is tasked with taking forward the ambitions and energy of the people and organisations who attended the summit.

This approach has already been adopted in some places, and is being extended in others as leaders recognise they need dedicated focus and resource to progress collaboration and partnerships. Investing in people and a programme that champions connection and integration, and breaks down the barriers in the way, could be really impactful.

Appendix 1: Summit Invitees

Cllr Angela Argenzio	Chair, Adult Health & Social Care Committee	Sheffield City Council
Nick Atkin	CEO	Yorkshire Housing Group
Clive Betts MP	MP	
Dr David Black	Medical Director	Sheffield Teaching Hospitals NHS FT
Andy Buck	Chair	Voluntary Action Sheffield
Alexis Chappell	Director of Adult Health & Social Care	Sheffield City Council
Oliver Coppard	Mayor	South Yorkshire Mayoral Combined Authority
Dean Fearon	Head of Neighbourhood Services	Sheffield City Council
Greg Fell*	Director of Public Health	Sheffield City Council
Victoria Gibbs	Head of Children's Commissioning	Sheffield City Council
Juliann Hall*	Care Health & Wellbeing Director	South Yorkshire Housing Association
Joe Horobin	Director of Integrated Commissioning	Sheffield City Council
Terry Hudsen	Chair	Sheffield NHS CCG
John Hudson	Director of Operations	Arches Housing
Douglas Johnson		Sheffield City Council
Becky Joyce	Development Director	Sheffield Children's NHS FT
Pat Keeling	Director of Strategy	Sheffield Health and Social Care NHS FT
Raymond Kinsella	Head of Neighbourhoods	Great Places
Jenny Llewellyn	Research and Knowledge Transfer Practitioner	University of Sheffield
Kate Martin	Executive Director of City Futures	Sheffield City Council
Tracey Nathan	Sheffield Hub Manager	Shelter
Kathryn Robertshaw*	Director	Sheffield Heath and Care Partnership
Judy Robinson	Chair	Healthwatch Sheffield
Mick Rooney		Sheffield City Council
Janet Sharpe	Director of Housing	Sheffield City Council
Helen Sims	CEO	Voluntary Action Sheffield
Dan Spicer*	Policy & Improvement Officer	Sheffield City Council
Tony Stacey	Chief Executive	South Yorkshire Housing Association
Mark Tuckett*	Director of Strategy and Planning	Sheffield Teaching Hospitals NHS FT
Laura White	Strategy & Partnerships Manager	Sheffield City Council
Catherine Pritchard	Policy & Improvement Officer	Sheffield City Council
Andrew van Doorn*	Chief Executive	HACT

* denotes a member of the Steering Group

Appendix 2: Agenda

The Summit was held in person on 21st June 2022, at The Circle in Sheffield.

12.30	**Arrival and lunch**
13.00	**Welcome and outline of the afternoon** Andrew van Doorn, CEO HACT
13.15	**Keynote from Oliver Coppard, Mayor of South Yorkshire**
13.45	**Aims and what you want to achieve**
14.00	**Setting the scene for Sheffield** • Cllr Angela Argenzio, Co-Chair, Adult Health and Social Care Committee, Sheffield City Council • Kathryn Robertshaw, Director, Sheffield Health and Care Partnership • Janet Sharpe, Director of Housing, Sheffield City Council • Tony Stacey, CEO SYHA
14.40[10]	**What's working elsewhere – experience from West Yorkshire** Sarah Roxby, Service Director Housing and Health, WDH and Programme Lead for Housing and Health, West Yorkshire Health and Care Partnership
14.55	Break
15.15	**Exploring key opportunities (1):** • ***Housing's role within Primary Care Networks*** (Greg Fell facilitating) • ***Health improvement and access for families and people experiencing homelessness*** (Andrew van Doorn facilitating) • ***Living well, Ageing well – integrating housing, health and social care*** (Juliann Hall facilitating)
16.00	**Exploring key opportunities (2):** • ***Tackling health inequalities through housing and community investment*** (Andrew van Doorn facilitating) • ***Mental health and wellbeing*** (Juliann Hall facilitating) • ***Impact through anchor networks with housing*** (Greg Fell facilitating)
16.45	**Key actions and commitments**
17.15	**Final thoughts and thanks** Greg Fell, Director of Public Health, Sheffield City Council
17.30	Close

[10] This session was not held, although a pre-recorded presentation was distributed to all participants.

About HACT

HACT partners with organisations across the housing sector and beyond to drive value for residents and communities through insight-led products and services which encourage innovation and foster collaboration. Our work around social value, community investment, health and the use of data, drive better understanding of the communities they serve and the social impact they have.

Our products, services, consultancy, and research help organisations:

- Develop new collaborations with the NHS that drives forward integration through our health consultancy and brokerage support.
- Identify cost benefits, evaluate performance, and deliver strategic insights through our programme of research and evaluation.
- Calculate their social value with rigour and objectivity by using our UK Social Value Bank.
- Measure impact, understand communities and demonstrate the value of community investment work through our insight tools.
- Provide a forum to network with partners to complement and strengthen success of delivery through our Centre for Excellence in Community Investment.
- Connect, share ideas and innovation and develop sector specific tools such as the UK Housing Data Standards.

HACT is a leading authority on the connection between NHS Providers and Housing Associations and is a key partner in the delivery of the Government's MoU between Housing and Health. HACT has published a range of resources on integrating housing within care pathways and the role of housing associations in major NHS estates programmes.

Contact Us

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HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health, SCC
Date:	29th September 2022
Subject:	Health and Wellbeing Board Terms of Reference
Author of Report:	Dan Spicer

Summary:

This paper sets out a set of proposed changes to the Health and Wellbeing Board's Terms of Reference, following completion of a review of the Board's work earlier this year. The Board are asked to discuss these, and agree to propose them to Full Council at the earliest opportunity for incorporation into the Council's constitution.

Questions for the Health and Wellbeing Board:

- Do the Board agree with the proposed changes to the Terms of Reference?

Recommendations for the Health and Wellbeing Board:

- Agree the proposed changes to the Health and Wellbeing Board Terms of Reference; and
- Agree to formally propose these changes to Full Council at the next available opportunity, for incorporation into the Council's Constitution.

Background Papers:

- *Health and Wellbeing Board Review – Proposal for Next Steps*
- *Appendix – Proposed revised Terms of Reference with tracked changes*

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

This report addresses the functioning of the Board and as a result relates to the Strategy as a whole.

Who has contributed to this paper?

Lucy Darragh – Graduate Management Trainee, Sheffield City Council Strategy & Partnerships Team

Health & Wellbeing Board Steering Group

HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

1.0 SUMMARY

1.1 This paper sets out a set of proposed changes to the Health and Wellbeing Board's Terms of Reference, following completion of a review of the Board's work earlier this year. The Board are asked to discuss these, and agree to propose them to Full Council at the earliest opportunity for incorporation into the Council's constitution.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 As the body with principal responsibility for addressing health inequalities in Sheffield, ensuring the Health and Wellbeing Board is fit for purpose is critical to this mission.

3.0 CONTEXT

3.1 In December 2021, the Health and Wellbeing Board commissioned a process of review and refresh in light of an identified need to refocus its efforts as Sheffield began to emerge from the immediate crisis period of the Covid-19 pandemic.

3.2 A series of other key implications on future Board activity were also identified:

- changes to local NHS structures, as per the Health and Care Act 2022;
- changes to Sheffield City Council's governance arrangements, of which the Health & Wellbeing Board is a part; and
- work being undertaken by Sheffield City Partnership to develop a new City Strategy.

3.3 This work reconfirmed the Board's collective commitment to, and focus on, addressing health inequalities in Sheffield as their primary purpose.

3.4 It also resulted in a number of proposals for the Board's work in the future:

- That the Board would maintain formal committee meetings but refocus their use to inform on ongoing work and highlight issues;
- That the Board's private strategy meetings would end and be replaced with a more open approach built on citywide conference events on issues related to the Joint Health and Wellbeing Strategy, with open invites;
- That the Board's Steering Group would be maintained as the body responsible for the Board's ongoing development and its forward agenda.

3.5 Finally, it recognised the need for membership changes to reflect NHS and SCC governance changes, to generate more system ownership of HWBB discussions and agreements, and to reflect the Board's commitment to an all-age approach.

4.0 CHANGES TO THE TERMS OF REFERENCE

4.1 The remainder of this report will set out section by section an explanation of changes proposed to the Board's Terms of Reference in light of the above. It will focus on major changes only; some minor changes for meaning aren't highlighted, but all are identified in a tracked changes version in the appendix to this paper.

4.2 As well as the membership and method changes highlighted above, it will also account for the formal end of commissioning in NHS resulting from the Health and Care Act 2022, and its replacement with a planning approach.

5.0 ROLE AND FUNCTION OF THE HEALTH AND WELLBEING BOARD

5.1 Paragraph 1.3 has been adjusted to prioritise the Board's focus on health inequalities, with improvement of planning, commissioning, and service delivery set out in service to this.

5.2 Paragraph 1.6 now reflects changes to the Board's role following the Health and Care Act 2022.

6.0 MEMBERSHIP

6.1 Following the formal end of commissioning in the NHS, member categories have been removed as these are now less relevant to the Board's work. This will also support a whole system approach and culture

6.2 The Board's membership has been adjusted to reflected the review discussion and wider governance changes, as per the table below:

Current membership	New membership/wording	Reason for change
Sheffield City Council Executive Member for Health and Social Care	Chair of Sheffield City Council Adult Health and Social Care Committee	Following the governance referendum, SCC has shifted to a Committee system. Since HWBB Member spaces are currently occupied by Executive Members, these are re-allocated to the Chairs of the relevant committees.
Sheffield City Council Executive Member for Education, Children and Families	Chair of Sheffield City Council Education, Children and Families Committee	
Sheffield City Council Executive Member for Neighbourhoods	Chair of Sheffield City Council Housing Committee	

and Community Safety		
Sheffield City Council Chief Executive	Sheffield City Council Chief Executive	No change. SCC CEX membership of the Board ensures links to all SCC services.
Sheffield City Council Director of Adult Social Services	Sheffield City Council Director of Adult Social Services	Statutory Member
Sheffield City Council Director of Children's Services	Sheffield City Council Director of Children's Services	Statutory Member
Sheffield City Council Executive Director for Place	Sheffield City Council Executive Director with responsibility for economic development	This will ensure links with the SCC approach to Levelling Up and broader economic development.
Director of Public Health	Sheffield City Council Director of Public Health	Statutory member
NHS Sheffield CCG Governing Body Chair	Remove	In the new NHS governance arrangements there is no equivalent of this role
NHS Sheffield CCG Accountable Officer	NHS South Yorkshire Executive Director for Sheffield	These are the direct equivalents of the former CCG posts.
NHS Sheffield CCG Director of Strategy	NHS Sheffield Director with responsibility for strategic leadership	
NHS Sheffield CCG Medical Director	NHS Sheffield Director with responsibility for clinical leadership	
Senior representative from NHS England	No replacement	Following the recent NHS reforms this place is no longer required.
Health & Care Partnership Programme Director	Nominated representative of the Health and Care Partnership	Reworded to allow flexibility should governance arrangements change.

NHS Provider – Clinical Representative	Nominated representative of NHS Acute Provider Trusts	One person to represent the NHS Provider constituency, to be nominated by provider members of the HCP. Will be required to engage with and represent all providers, not just their organisation. Removing one provider place allows flexibility to broaden membership.
NHS Provider – Non-Executive Representative	Remove	
NHS Sheffield CCG Governing Body GP	Nominated clinical representative of Primary Care Networks	There is no equivalent of CCG Governing Body GPs under new NHS governance but it is desirable to maintain a primary care perspective in Board discussions
New Member	Nominated representative of partners working with or for children and young people	This reflects the HWBB need to adjust its membership to make it properly "all-age", with the individual to be nominated through relevant partnerships.
New Member	Nominated representative of partners working to support mental health and wellbeing	This reflects the need to ensure parity between physical and mental health, with the individual to be nominated through relevant partnerships.
VCF Provider	Representative from a VCF organisation working citywide	Adjustments made to ensure a range of perspectives from VCF partners are reflected in Board discussions, with recruitment to these roles to be done in partnership with the sector.
VCF Organisation	Representative from a VCF organisation working within a locality	
New Member	Representative from a VCF organisation working with a specific group	
Blue Light Service	Representative of South Yorkshire Police	SYP have attended for the lifetime of this place, and have a strong interest in the downstream impacts of health inequalities
Chair of Healthwatch Sheffield	Chair of Healthwatch Sheffield	Statutory member
University	Representative of the University of Sheffield	Providing two formal places allows for clearer engagement with the universities

	Representative of Sheffield Hallam University	as corporate institutions.

6.3 Paragraph 2.2 now explicitly references citizens to emphasise engagement outside formal institutions, and has added an option for the Board to co-opt members where relevant to aid flexibility.

6.4 Paragraph 2.3 has been added to set out clearly the aims for planned conferences.

6.5 Paragraph 2.5 has been added to indicate that vacancies will be recruited to formally, using the Board's Steering Group to guide this process.

7.0 GOVERNANCE

7.1 The Board has been co-chaired since its inception by an elected member of Sheffield City Council and the Chair of the Clinical Commissioning Group Governing Body, and this has been seen as a valuable symbol of partnership working. However, there is no non-executive equivalent of the Chair of the Governing Body in the new NHS governance arrangements.

7.2 As a result the Board need to consider whether to end the co-chairing arrangement in order to maintain this as a non-executive role, or to maintain the partnership arrangement and accept that the NHS co-chair will be someone with executive responsibilities.

7.3 As a result, two versions of paragraph 3.1, which deals with chairing arrangements, are proposed for consideration. The first of these sets the chair as the Chair of the SCC Adult Health and Social Care Committee; the second maintains co-chairing, with this being between the Chair of the Adult Health and Social Care Committee, and the NHS South Yorkshire Executive Director for Sheffield. The Board are asked to give their view on which of these they would prefer to propose to Full Council for formal incorporation.

7.4 Paragraph 3.3 has been adjusted to update quorum arrangements to reflect the removal of categories of membership indicated above, and following this to set a quorum at a minimum number of Board members. This has been set at 25%, which reflects the rules for Full Council; it is felt that the standard of 2-3 members used for committees is too low for a strategic partnership.

7.5 The reference to scrutiny committees in paragraph 3.6 has been removed to reflect SCC constitutional changes.

7.6 Additions have been made to paragraph 3.7 to reflect changes to NHS governance.

8.0 MEETINGS, AGENDAS AND PAPERS

8.1 Paragraph 4.1 has been adjusted to remove private strategy development meetings as per the review recommendations.

8.2 Paragraphs 4.7 and 4.8 have been added making commitments to produce and discuss an annual report, and hold conferences on strategic issues.

9.0 ROLE OF A HEALTH AND WELLBEING BOARD MEMBER

9.1 Paragraph 5.1 has been adjusted to include a role in promoting and supporting conference events.

9.2 Paragraph 5.2 has been extracted from the bullet list in 5.1 to emphasise this ask of Board members.

10.0 ENGAGEMENT WITH THE PUBLIC

10.1 The section title has had a reference to providers removed as these organisations are now formally included in the Board's membership.

10.2 Paragraph 6.1 has been adjusted to reflect the removal of board member categories, with the reference to Independent Voice members removed.

10.3 Paragraph 6.3 has been added to set out the purpose of conference events, with consequent adjustments to paragraph 6.4 to emphasise the broader role of VCS organisations in engagement.

10.4 The commitment to maintain a website and regular newsletter removed, reflecting the support resource available.

11.0 QUESTIONS FOR THE BOARD

11.1 Which of the proposed approaches to chairing arrangements do the Board want to pursue?

11.2 Do the Board agree with the proposed changes to the Terms of Reference?

12.0 RECOMMENDATIONS

12.1 The Board are recommended to:

- Agree the proposed changes to the Health and Wellbeing Board Terms of Reference; and
- Agree to formally propose these changes to Full Council at the next available opportunity, for incorporation into the Council's Constitution.

Appendix

Sheffield Health and Wellbeing Board

Terms of Reference

Approved by Full Council ~~6th~~ Xth ~~February~~ [Month] ~~2019~~2022

1. Role and Function of the Health and Wellbeing Board

1.1 The Sheffield Health and Wellbeing Board (the Board) is established under the Health and Social Care Act 2012 as a statutory committee of Sheffield City Council (the Council) from 1 April 2013. However, it will operate as a multi-agency board of equal partners.

1.2 The Board will develop and maintain a vision for a city free from inequalities in health and wellbeing, taking a view of the whole population from pre-birth to end of life.

1.3 The Board will be the system leader for health & wellbeing, acting as a strong and effective partnership to:

- Maximise the impact of all institutions in Sheffield on reducing health inequalities in the city; and ~~improve the commissioning and delivery of services across the NHS and the Council, leading in turn to improved health and wellbeing outcomes and reduced health inequalities for the people of Sheffield.~~
- Improve the planning, commissioning, and delivery of services across the NHS and Council.

~~1.3~~1.4 In doing this, the Board will take an interest in all the determinants of health and wellbeing in Sheffield and will work across organisational boundaries in pursuit of this.

~~1.4~~1.5 The Board will be ambitious for Sheffield and hold organisations in Sheffield to account for the delivery of the Board's vision for the city. It ~~should enable~~will support organisations to work in an integrated way, for the purpose of advancing the health and wellbeing of people in Sheffield.

~~1.5~~1.6 The Board is statutorily required to carry out the following functions:

- To undertake a Joint Strategic Needs Assessment (JSNA)[1];
- To undertake a Pharmaceutical Needs Assessment (PNA)[2];
- To develop and publish a Joint Health and Wellbeing Strategy (JHWS) for Sheffield[3]

[1] Section 116 Local Government and Public Involvement in Health Act 2007 (the LGPIHA 2007)
[2] Section 128A National Health Service Act 2006 (the NHSA 2006).
[3] Under Section 116A LGPIHA 2007

- To provide an opinion on whether the Council is discharging its duty to have regard to the JSNA, and the JHWS, in the exercise of its functions[4];
- To contribute to the NHS South Yorkshire Integrated Care Partnership's Integrated Care Strategy, setting the direction for the Integrated Care Board;
- ~~To review the extent to which the Clinical Commissioning Group (CCG) has contributed to the delivery of the JHWS[5]; to provide an opinion to the CCG on whether their draft commissioning plan takes proper account of the JHWS[6]; and, to provide an opinion to NHS England on whether a commissioning plan published by the CCG takes proper account of the JHWS[7]~~To engage with the Integrated Care Board ~~;~~on their five year forward plan, setting out how the ICB will deliver its core duties including what it will do to implement the JHWS, before the start of each financial year;
- To produce a statement on the Board's final opinion on this plan, following consultation with the ICB;
- To contribute to NHS England's annual performance assessment of how well the ICB is discharging its duties, including its contribution to delivery of the JHWS;
- To support joint planning and commissioning and encourage integrated working and pooled budget arrangements[8] in relation to arrangements for providing health, health-related or social care services;
- To discharge all functions relating to the Better Care Fund that are required or permitted by law to be exercised by the Board; and
- To receive and approve any other plans or strategies that are required either as a matter of law or policy to be approved by the Board.

~~1.6~~1.7 In addition to these the Board will also take an interest in how all organisations in Sheffield function together to deliver on the Joint Health & Wellbeing Strategy.

~~1.7~~1.8 The Board will own and oversee the strategic vision for health and wellbeing in Sheffield, hold all partners and organisations to account for delivering against this by taking an interest in all associated strategies and plans and, when appropriate, requesting details on how specific policies or strategies help to achieve the aims of the Joint Health & Wellbeing Strategy.

~~1.8~~1.9 The Board will continue to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of its statutory duty to encourage integrated working ~~between commissioners~~. This will include signing off quarterly and annual Better Care Fund submissions.

[4] Under Section 116B LGPIHA 2007

[5] ~~Under Section 14Z15(3) and Section 14Z16 NHSA 2006~~

[6] ~~Section 14Z13(5) NHSA 2006~~

[7] ~~Section 14Z14 NHSA 2006~~

[8] In accordance with Section 195 Health and Social Care Act 2012. This includes encouraging arrangements under Section 75 NHSA 2006.

2. Membership

2.1 The membership of the Board is as follows:

- ~~Sheffield City Council:~~
- ~~Cabinet Member~~Chair of Sheffield City Council ~~for~~ Adult Health & Social Care Committee
- ~~Cabinet Member for~~Chair of Sheffield City Council Education, Children & Families Committee
- ~~Cabinet Member for Neighbourhoods & Community Safety~~Chair of Sheffield City Council Housing Committee
- Sheffield City Council Chief Executive
- Sheffield City Council Director of Adult Social Services (or the officer fulfilling this statutory role)
- Sheffield City Council Director of Children's Services (or the officer fulfilling this statutory role)
- ~~Executive Director for Place~~Sheffield City Council Executive Director with responsibility for economic development
- Sheffield City Council Director of Public Health
- NHS South Yorkshire ~~Sheffield NHS Clinical Commissioning Group~~
- ~~Governing Body Chair~~Executive Director for Sheffield
- ~~One other Governing Body GP~~NHS Sheffield Director with responsibility for strategic leadership
- ~~Accountable Officer~~NHS Sheffield Director with responsibility for clinical leadership
- ~~Medical Director~~
- ~~Director of Strategy~~
- ~~Other Commissioners~~
- ~~Senior Representative from NHS England~~
- Nominated representative of the ~~Providers~~
- ~~Accountable~~ Health and Care Partnership ~~Programme Director~~
- Nominated representative of NHS ~~NHS Provider – Clinical Representative~~Acute Provider Trusts
- Nominated clinical representative of ~~NHS Provider – Non-Executive Representative~~Primary Care Networks
- Nominated representative of partners working with or for children and young people
- Nominated representative of partners working to support mental health and wellbeing
- Representative from a VCF organisation working citywide~~VCF Provider~~
- Representative from a VCF organisation working within a locality~~VCF Organisation~~

- Representative from a VCF organisation working with a specific group
- Representative of ~~Blue Light Service~~South Yorkshire Police
- ~~Independent Voice~~
- Chair of Healthwatch Sheffield
- ~~Representative of Director of Public Health~~
- University of Sheffield
- Representative of Sheffield Hallam University

2.2 Citizens or ~~O~~other representatives from the wider health and wellbeing community in Sheffield may be invited to attend the Board ~~from time to time~~ to contribute to discussions ~~of specific issues~~. The Board may also co-opt members where it will be beneficial to ongoing conversations and related work.

~~2.1~~2.3 Broader attendance will be especially encouraged outside of the formal committee meetings, with larger conference events aiming to link Board members as key decision makers in the city with a citizen and service user perspective, and with organisations, individuals and experts in the field who can bring a diverse range of insights into the discussion. Attendance at events should be representative of the city as a whole, as appropriate for the issue at hand, and the Board will ensure that everyone attending these events speaks on the same terms and with the same expectations of being heard.

2.4 Any changes to personnel will be approved through Full Council on an annual basis.

~~2.2~~2.5 Where places are or become vacant and are not related to a specified individual, these will be recruited to through an exercise conducted by the Board's Steering Group.

3. Governance

3.1 **Chair:** The Board will be ~~co-~~chaired by the ~~Council Cabinet Member for~~Chair of the SCC Adult Health & Social Care Committee~~and the Chair of the CCG, with chairing of meetings generally alternating between them~~.

or

Chair: The Board will be co-chaired by the Chair of the SCC Adult Health & Social Care Committee and the NHS South Yorkshire Executive Director for Sheffield.

3.2 Attendance at meetings and deputies: In order to maintain consistency it is assumed that Board members will attend all meetings as far as possible. Each member must name 1 deputy, who should be well briefed on the Board's purpose and activities, fulfil the same or similar function in their primary role (as opposed to being from the same organisation), and attend meetings and vote on behalf of the member when they are absent.

3.3 Quorum: The quorum for a meeting of the Board shall be one quarter of the whole number of the membership (including vacancies).~~1 Elected Member of the Council & 1 other~~

~~Council Representative (Elected Member or Officer), 1 CCG Governing Body GP and 1 other CCG Representative, 1 Provider Representative, and 1 Independent Voice Representative, with an in-meeting majority for Commissioners.~~

3.4 **Decision-making and voting:** The Board will operate on a consensus basis. Where consensus cannot be achieved the matter will be put to a vote. Decisions will be made by simple majority: the Chair ~~for the meeting at which the vote is taken~~ will have the casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

3.5 **Authority of representatives:** It is accepted that some decisions and~~-~~/~~-~~or representations will need to be made in accordance with the governance procedures of the organisations represented on the Board: however, representatives should have sufficient authority to speak for their organisations and make decisions within their own delegations.

3.6 **Accountability and scrutiny:** As a Council committee, the Board will be formally accountable to ~~the~~ Full Council. ~~Its work may be subject to scrutiny by any of the Council's relevant scrutiny committees~~

3.7 **Relationship to other groups:** The Board has formally agreed a protocol with the city's Safeguarding Boards. The Board will seek to develop close relationships with the city's ~~Accountable~~ Health and Care Partnership, ~~and~~ Sheffield City Council's ~~Scrutiny~~ Policy Committees, the NHS South Yorkshire Integrated Care System, and the Sheffield Joint Commissioning Committee, as part of its work to hold the health and wellbeing system to account. It will also develop relationships with other bodies in the city such as the Sheffield City Partnership Board and Sheffield ~~Safer & Sustainable Communities~~ Community Safety Partnership, especially where the agendas of such bodies overlap with the Board's.

4. Meetings, agendas and papers

4.1 The Board will normally meet quarterly in public~~, interspersed with private strategy development meetings.~~. There will be no fewer than 2 meetings per financial year, with a maximum of 32 weeks between meetings.

4.2 Dates, venues, agendas and papers for public meetings will be published in advance on the Council's website.

4.3 The ~~co-~~Chair~~s~~ will agree the agenda for each meeting, supported by ~~an officer subgroup~~the Board's Steering Group.

4.4 Agendas and papers will be circulated to all members and be available on the Council's website 7 days in advance of the meeting

4.5 Minutes will be circulated to all members, and published on the Council's website as soon as possible after the meeting

4.6 It is expected that those who write papers will work collaboratively with others to provide a city-wide perspective on any given issue.

4.7 The Board will receive an Annual Report at its March meeting, using this to understand its impact and establish aims for the year ahead.

4.8 The Board will also convene regular city conferences with open invites on topics that are relevant to the JHWS.

~~4.6~~

5. Role of a Health and Wellbeing Board member

5.1 All members of the Board, as a statutory committee of the Council, must observe the Council's code of conduct for members and co-opted members. Other responsibilities include:

- Prioritising their attendance at Board meetings and positively contributing to discussions, reading and digesting any documents and information provided prior to meetings.~~Attending Board meetings whenever possible and fully and positively contributing to discussions, reading and digesting any documents and information provided prior to meetings~~
- Playing a strong role in promoting the Board conference events, and identifying relevant people to attend and contribute.
- ~~The membership of the Health & Wellbeing Board is constructed to provide a broad range of perspectives on the development of strategy. With this in mind, members are asked to bring the insight, knowledge, perspective and strategic capacity they have as a consequence of their everyday role, and not act simply as a representative of their organisation, but with the interests of the whole city and its residents at heart.~~
- Fully and effectively communicating outcomes and key decisions of the Board to their own organisations, acting as ambassadors for the work of the Board, and participating where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media
- Contributing to the development of the JSNA and JHWS
- Ensuring that planning and commissioning ~~is~~are in line with the requirements of the JHWS and working to deliver improvements in performance against measures within the public health, NHS and adult social care outcomes frameworks
- Declaring any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
- Acting in a respectful, inclusive and open manner with all colleagues to encourage debate and challenge.

5.2 The membership of the Health & Wellbeing Board is constructed to provide a broad range of perspectives on the development of strategy. With this in mind, members are asked to bring the insight, knowledge, perspective and strategic capacity they have as a consequence of their everyday role, and not act simply as a representative of their organisation, but with the interests of the whole city and its residents at heart.

6. Engagement with the public ~~and providers~~

6.1 Healthwatch Sheffield is the Board's statutory partner for involving Sheffield people in discussions and decision-making around health and wellbeing in the city. It is expected that the Healthwatch Sheffield representative(s) will clearly ensure Sheffield people's views are included in all Board discussions, with ~~Elected Members, and other Independent Voice~~ all other Board members ~~also having a role~~expected to contribute in this regard.

6.2 Formal public meetings will be held quarterly, with members of the public invited to ask questions. An answer may take the form of:

- An oral answer
- A written answer to the member of the public, circulated to the Board and placed on the Council's website
- Where the desired information is contained in a publication, a reference to that publication.

The Board's chairs retain the right to restrict the length of time given to answering public questions at any meetings held.

6.3 The Board will work to engage with the public on the issues affecting health and wellbeing in Sheffield through a range of means. This will include conferences, which will:

- Bring in a broader range of voices and more diverse insight into health and wellbeing priorities set out by the Board;
- Provide opportunity for decision makers in the city to come together with people experiencing health inequalities, working towards co-produced solutions; and
- Where possible, provide the opportunity for the Board to get out of its normal meeting settings and into communities.

~~6.3~~6.4 The Board will work with Healthwatch Sheffield and voluntary sector organisations to ~~engage with the public on the issues affecting health and wellbeing in Sheffield through a range of means,~~ ensur~~inge~~ the output from ~~this~~ engagement is linked to the Board's Forward Plan, and is fed into and reflected in Board discussions. This work will:

- Provide an avenue for members of the public to impact on the Board's discussions and work;

- Engage the public and/or providers in the development of the Joint Health & Wellbeing Strategy;
- Develop the Board's understanding of local people's and providers' experiences and priorities for health and wellbeing;
- Communicate the work of the Board in shaping health and wellbeing in Sheffield;
- Develop a shared perspective of the ways in which providers can contribute to the Board's delivery.

~~6.4 The Board will maintain a website with up-to-date information about its work and send out regular newsletters.~~

7. Review

7.1 These Terms of Reference will be reviewed annually.

HEALTH AND WELLBEING BOARD PAPER
FORMAL PUBLIC MEETING

Report of:	Greg Fell, Director of Public Health, SCC
Date:	29th September 2022
Subject:	Joint Health & Wellbeing Strategy Review: Summary of Findings
Author of Report:	Freyja Cummings

Summary:

This report highlights the main findings of the Health and Wellbeing strategy review and provides recommendations for changes and actions. The review set out to explore and address the nine ambitions of the Health and Wellbeing Strategy published in 2019, health areas connected to/linked with the Health and Wellbeing Strategy, and health-related anchor organisations in the city. This report suggests that the strategy itself is the right strategy, but there is some further work to be done to ensure better engagement and delivery of the strategy. Questions for the board to consider are included in the paper and responses to these will be incorporated into the ongoing review work.

Questions for the Health and Wellbeing Board:

The Board are asked to consider the following questions:

- Do the Board agree that no major changes are required to the Strategy at this time?
- Are there additional things members of the board should be doing, beyond the actions set out in the recent review of the Board, to address the concerns raised in the interviews?
- What can Board members do in their individual and corporate roles to support driving action and impact?

Recommendations for the Health and Wellbeing Board:

The Board are recommended to note the report alongside other, complementary work on the Board and its Terms of Reference and consider its responses to the questions outlined above.

Background Papers:

Live Analysis of Transcripts: Coding Feelings v1.1.1 – Appendix 1.

Live Analysis and Methodology NEW 3 – Appendix 2.

Interview Questions – Appendix 3

Health and Wellbeing Board Review – proposal for next steps

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

All nine ambitions will be positively affected by the data from this report.

Who has contributed to this paper?

Lorraine Gosnell and Christopher Gibbons

JOINT HEALTH AND WELLBEING STRATEGY REVIEW: SUMMARY OF FINDINGS

1.0 SUMMARY

1.1 This report sets out the context for and key findings from work commissioned by the Director of Public Health to review the Joint Health and Wellbeing Strategy. It then sets these in the context of complementary work to review the Board's ways of working and Terms of Reference and asks the Board to consider any additional measures that should be taken to address questions around impact and delivery.

2.0 HOW DOES THIS IMPACT ON HEALTH INEQUALITIES IN SHEFFIELD?

2.1 Sheffield's Joint Health and Wellbeing Strategy (JHWBS) has an overall goal of reducing health inequalities. Effective delivery of a coherent Strategy is part of addressing health inequalities in the city. A central goal for the board and its strategy should be addressing the gaps in Healthy Life Expectancy, economic prosperity and inclusive growth, climate resilience, and education, skills and best start in life life/chances - although no strategy can address these without resourcing from central government that is adequate to meet the challenges, accelerate the execution of interventions already in place and/or provide new powers with commensurate resourcing system by system and topic by topic.

3.0 CONTEXT AND PROCESS FOR THE WORK

3.1 Sheffield's Joint Health and Wellbeing Strategy was agreed by the Board in March 2019 and formally adopted by SCC Cabinet the following month. However, due to the impact of the pandemic, it has not been possible to progress work on delivering the Strategy in the way intended.

3.2 With this in mind, as Sheffield begins to emerge from the pandemic, the Director of Public Health commissioned a light touch exercise to assess whether the Strategy is still fit for the challenges facing Sheffield's health and wellbeing, and what if anything needs to change.

3.3 This exercise took the form of a series of interviews, focused on assessing attitudes towards the aims and content of the Strategy and whether these were still fit for purpose, and towards delivery and impact resulting from the Strategy. The intention was that this would complement the review of the Board conducted across the end of 2021 and early 2022.

3.4 Interviewees made up of a selection of members of the Sheffield Health & Wellbeing Board, designated leads for one the nine ambitions of the Health & Wellbeing Strategy, leads in a health area connected to/linked with the Health & Wellbeing Strategy, or

leads in health-related anchor organisations in the city. Interviews took place between May and mid-June 2022.

3.5 The data has been framed by the question, 'What is the feeling about the delivery of the Health & Wellbeing Strategy, the degree of success in delivering against the nine life course ambitions, and critical reflection around the role of the Board in the delivery of the HWB Strategy'. Interviewees were free to openly answer questions, the interviews were guided by the questions found in Appendix 3.

4.0 KEY FINDINGS FROM INTERVIEWS

4.1 Full details of the analysis of interview responses can be found at Appendix 1 of this report. Overall, the key findings for the Board to consider are as follows:

- **The overall goal and ambitions set out in the Strategy remain in broadly the right place**, with Board members in agreement on this point. However Board members do see limitations in how the strategy is delivered and how board members engage and contribute towards its implementation.
- **Board members do not feel sufficiently connected to work being done to deliver the Strategy whether explicitly in the name of the JHWBS or linked to the overall goal but not name checked**, linking this to a lack of effective and reliable communication to and from the Board. This suggests action is needed to address the visibility of the impact the strategy (and contributory projects and developments) is having on the population and the determinants of health, such as spending time and resources sharing stories, developments, and successes.
- **Board members would like to emphasise action over rhetoric**, with a desire for more clearly articulated action plans. However, the key rate limiting step here is that the board is simply not resourced to write action plans for each of the strategic aims. Furthermore, this finding should be viewed in the context of other feedback from the interviews about communication/disconnect and visibility – there is a perception that action isn't taking place but that is perhaps more a symptom of visibility and communication rather than a lack of action as there is a huge amount of work towards the 9 key aims that the board simply hasn't been sighted on including smoking, obesity, physical activity etc.
- **Feeling of isolation/separateness/disconnect from the strategy, the strategy delivery, and from the board** Mainly stemming from a lack of effective and reliable communication.
- **Gaps in communication from and to the Board -** Unsureness of what is being delivered/disconnect from information.
- **The Board and how it could be as the lever for action/direction/'clout'. The board has a lot of power and needs to use it to action change –** not just writing down a strategy, but encouraging behaviour changes within the board, and constituent members

- **Call for focus - a defined clear agreed shared focus and commonality of purpose.** In each of the 9 ambitions the original intention was to set out (with wide range of stakeholders) a sense of state of the art and big priorities within that space. Obviously the pandemic knocked us completely off course. We made good on some of these – can argue housing summit made good on some of this, as did work on early years etc.

5.0 WHAT NEEDS TO HAPPEN TO MAKE A DIFFERENCE

4.2 It is clear from this work that there is broad support for the Strategy as it is: a fundamental rewrite is not needed prior to the planned expiry of the current strategy in 2024.

4.3 The messages highlighted above complement those received through the review of the Board itself conducted earlier this year, with changes being made to the Board's way of working that should help to address:

- Committee meetings used to highlight issues and communicate progress in relevant areas to ensure Board members are more aware of the range of work ongoing in Sheffield;
- Strategy meetings have been replaced by broader conferences designed to identify actions related to Strategy ambitions or areas of significant impact on health, leading to commitments against which partners can be held accountable;
- A new commitment to producing an Annual Report to highlight the impact of the Board's work, and areas of progress, and to regularly refresh collective commitment to the aims of the Strategy.

4.4 In relation to concerns raised around delivery and impact, the Board need to consider resource limitations. The Board's support function is not resourced to directly deliver or programme manage work on the Board's behalf. This being the case action and impact will need to flow from a combination of:

- Board members taking the content and outcomes of discussions at Board meetings and conferences with them, and factoring them into their work; and
- Organisations and partnerships internalising the Joint Health and Wellbeing Strategy as a key strategy for Sheffield, and proactively interrogating what they could be doing differently to support delivery on its aims, including reporting, or bringing items for discussion, to the Board when appropriate.

6.0 QUESTIONS FOR THE BOARD

4.5 The Board are asked to consider the following questions:

- Do the Board agree that no major changes are required to the Strategy at this time?

- Are there additional things members of the board should be doing, beyond the actions set out in the recent review of the Board, to address the concerns raised in the interviews?
- What can Board members do in their individual and corporate roles to support driving action and impact?

7.0 RECOMMENDATIONS FOR THE BOARD

4.6 The Board are recommended to note the report alongside other, complementary work on the Board and its Terms of Reference and consider its responses to the questions outlined above.

Appendix 1:

Live Thematic Analysis for Health & Wellbeing Strategy Review

The *Data Corpus* consists of 1-1 virtual interviews conducted with twenty-one pre-selected participants, made up of a selection of members of the Sheffield Health & Wellbeing Board, designated leads for one the nine ambitions of the Health & Wellbeing Strategy, leads in a health area connected to/linked with the Health & Wellbeing Strategy, or leads in health-related anchor organisations in the city.
For the purposes of this thematic analysis, the data set used is qualitative data gathered from the individual interviews and the data items consist of the individual interviews, and data extract refers to an individual coded chunk of data, which has been identified within, and extracted from, a data item.
The data has been identified by the question, ***What is the feeling about the delivery of the Health & Wellbeing Strategy, the degree of success in delivering against the nine life course ambitions, and critical reflection around the role of the Board in the delivery of the HWB Strategy***, and to identify, (discover Rubin and Rubin (1995: 226)) analyse and report on all instances in the corpus where there was prevalence of patterns of feelings around themes and concepts within data emerged.
The approach which I have taken is a thematic decomposition analysis (e.g., Stenner, 1993; Ussher & Mooney-Somers, 2000) which identifies patterns (themes, stories) within data, and theorises language as constitutive of meaning and meaning as social. The approach taken was to undertake a search for certain themes or patterns across the (entire) data set, rather than within a data item, such as an individual interview or interviews from one person. ***The rationale was to use thematic analysis as a method which works both to reflect reality, and to unpick or unravel the surface of reality, of the success of the delivery of the HWB Strategy and how the Board in reality is seen through the lens of the participating interviews and the data corpus***.

The discovered patterns and themes include:
Uncertainty, Unsureness and frustration of the level of progress the Board has made affected by a lack of knowledge

How much has really changed in the life of the strategy since 2019	1. Unsure about what is different now from then
The 10-15 Life Expectancy Gap and the 15-year Healthy Life Expectancy Gap – how much difference have we made, in terms of real lasting difference. I am not sure we have.	2. Unsure of the difference the strategy has made

I know how difficult it is to make a reasonable measure of impact of the strategies. I don't know how much it achieved its aims – it's difficult to measure that.	1. Feeling of not having the knowledge to understand because of a lack of information from the Board
I don't get any sense of where we are as a city on education and schools.	2. Feeling at a loss to understand

What are the priorities and how can we bring in people to help take leadership for these priorities I'm not sure we have done that?	1. Lack of knowledge, lack of being informed, feeling of unsurety in the leadership
Physical Activity is a big part of the 9 ambitions. It's such a significant role but no one ever asked me to summarise its impact.	2. A heartfelt desire to be part of the board, and feeling outside of the board

I don't know. Last 2 years will not have done anything to improve this gap, but I don't know where we are now	1. feeling of unsureness, lack of knowledge on what has been done to make things better for life chances

How many people know that our overall goal is our No 1 priority is to reduce the gap. I don't think people know that. Not many people know that's our goal our No 1 priority.	1. Frustration that the goal of the strategy isn't known widely

I know about the compassionate city work but don't know what people's experiences are at the end of their life	1. Not having full knowledge, only partial knowledge, a gap in knowledge

Attendance data is a really good measure to measure are we really getting it right for children. We know we don't have great attendance in the city – it's part of the 1-year plan for the city for us as a council – I'm not sure that's being fed into the HWB Board.	1. Children's education, and the board being well informed

Concern, Worry and Anxiety about the aftermath of Covid on loneliness and Isolation

The impact of Covid and isolation - social prescribing has a job to reintegrate people back into life.	2. The impact and re-integration of people into society/communities and feeling isolated /alone
In the last 2 years a lot of people have died prematurely due to Covid, and a lot of people have had their deaths managed in the community	3. Covid/deaths and the impact on communities (grief, loss, isolation, abandonment)

Access to care and social contact has been exacerbated by Covid but loneliness and social isolation is just not limited to aging well.	1. Young people not normally viewed as lonely, or isolated, are affected post-Covid - its not exclusive to the aging

Young people are struggling and have struggled with loneliness and isolation, and we know there are direct links to poverty and disadvantage.	

Covid has had a massive impact and it will have affected our population – we need to focus on a redress.	1. Not to ignore the impact of Covid, to address it
We have to address some of the fundamental issues in society – people living their worse lives rather than their best life – and to be able to access what they need to live a good life.	2. What are the fundamentals for people to be able to live a good life?

Inequality exacerbated by Covid. Have we successfully understood and targeted support to those communities which are under-served and in the worse conditions for health & wellbeing.	1. The effect on communities, is this being thought about?

I think that Life Expectancy will have remained the same, but that Healthy Life Expectancy (HLE) has been reduced, 13 years of this government, austerity, and the pandemic, and now the Cost-of-Living crisis.	1. Healthy Life Expectancy and the reduction in life years
It's been a challenging time with the pandemic, everyone has been so stretched.	1. Impact on people by the pandemic
Relationships have been lost or suffered not seeing one another face to face, and the chat over the cup of coffee after a meeting – has contributed to statis, but it feels like we are ready for a refresh.	2. Impact on relationships but a hopefulness, a readiness for a refresh
I welcome closer contact with SCC Leads …the data insights Team and physical activity across the city. We use to have this, but we lost this during Covid – the ability to know who and what opportunities and how we can support each other with data sets we can rely on.	3. Feeling of a loss and a desire to have it restored

We need to sit back now and to reflect/take scope on how to take it forward and the impact Covid has had	1. Need to take time to reflect on where to go next

on CYP and Families we need to take stock of that too.	2. Need to take time to reflect on the impact of Covid on families and children
Covid and its impact – that created challenges not only by increasing inequality but on Schools the impact on teaching and learning	3. The increase in inequality and on children's learning development
as stakeholders we were distracted away from the Ambitions and the HWB Strategy to Covid and responding to it, as separate organisations, and our response to how it impacted on us	4. Covid as a distraction taking away from the strategy and the board's focus

1500 people died in Sheffield in the pandemic	1. The stark reality of Covid on Sheffield as a city

The impact of Covid and from the EY workshop which I was involved in the loss of young children's' social skills and motor skills	1. Covid and early child development – worry about the loss of skills

I would ask to add in, given the past two and a half years and Covid – the impact of disadvantage, Pupil Premium and Poverty – it's a significant gap which has been crystalized by Covid-19 and post-Covid	1. Worried about the effect of covid on children by the increase in poverty and inequality
There is an issue re attendance from Covid in that there is a cohort which haven't returned from Covid in Secondary schools but also in Primary school sector – yes, its linked to county lines/gangs/risks and so on, but there are behavioural shifts in a cohort of young people not returning to school. I would suspect this is a national trend.	2. Young people and school attendance and the effects post-covid, and wondering where Sheffield is in relation to the rest of the country

national external factors which have impacted on the strategy and its delivery – namely, the impact of Covid, the Cost-of-Living Crisis. It won't have narrowed the gap	1. the negative impact of external factors on life expectancy

Key focus should be on life expectancy – it's on people's agenda and is higher now than it's ever been because of Covid and the last 2 years. It has a lot to answer for in raising inequalities.	1. Acute awareness of inequalities post Covid and people's life chances

A feeling of a change in needs because of Covid, and a desire for a change in the way the Board relates to its partners

On covid, coming through Covid, the strategy needs to be quite agile	1. Expression of a need post-covid for a different approach
During Covid VAS was gathering quite a lot of insights on people's behaviours, and more broadly how the sector were seen as an equitable partner in the city. Seen a shift in the conversation in the way we are working with each other and we want to build on that	2. A request for equity as a partner in relationship with and to the Board

We are not even playing catch-up we are skimming the surface. Covid has overloaded the system.	1. Not really getting to the nub of the situation
We also definitely need to have something post-covid to fix and mend what the disaster has done e.g., Hurricane Catriona and the devastation – shouldn't we be focusing on getting back what we lost	2. What are we doing to deal with consequences of Covid

Concerns and frustration at the specifics of the type of broad stroke groupings/language used in the strategy

the key word in all of the ambitions is "everyone" and that's the kicker. Have we done that for everyone - improvement is not "everyone has"?	3. Who do we mean when we say everyone – need for language used/terms used to be very clearly articulated
A lot of good work has happened, but it's a bold statement to say for 'everyone' – there will always be structural barriers	4. Effect of other barriers to the life course and to a healthy life expectancy

There is also something about that word 'fulfilling' in this ambition … we know that we have an over-qualified workforce qualified to Level 4, but are choosing to work at Level 2, so under-occupation is a choice. As an example, a teacher who leaves the profession to become a Teaching Assistant – are they doing that to lead a more fulfilling life? Or are they doing it for health reasons and to live a fulfilling life? A large part of 'fulfilling' is subjective to the person making that choice – that's hard to measure?	1. Being clear on the terminology we use and what we mean by that 2. How do we measure these?

Strong feeling of opinion on the role of the board and influence and frustration with passivity of the board and a frustration not understanding its power as an influencer

The Health & Wellbeing Board needs to be a better meeting, better organised and understand its powers better.	1. How the Board can be better in contrast to how it is perceived to be currently i.e. not doing its best
It's not enough to go 'this is our strategy' the Health & Wellbeing Board needs to be a pressure organisation – it needs to be lobbying for these who can deliver, it needs to be more active in influencing that underneath it	2. Strong feeling about the role of the Board as an influencer with the power to influence
The Board needs to be making demands to those who hold the purse strings. It should be reversed – HWB Board should be the influence, and the strategy should set out its stall.	3. How the board and the strategy fit together
What influence do you want to have on the health service and health outcomes? – a Compassionate City type of stuff within the whole city to produce a cultural shift – to make it normal for children, families. how do you influence that and Health Promotion?	4. questioning a cultural shift, for the board, and coming from a more caring, empathetic feeling centre

Operationalising a systems approach is difficult – organisations can't see what's in it for them, feel threatened by it. But it's really critical – how do we support stakeholders' organisations and the HWB Board to work in that way	1. fear of what needs to change but willingness to help support that change, to work in this way 2. the role of the HWB Board in driving this change

I see the Health & wellbeing Board as the mechanism for that connectivity	1. how the Board is seen as having an active direction
it would be good to connect the National Centre Board which sits alongside Sheffield's H&WB Board and to strengthen those connections, to connect up what's already there, to make it more robust.	2. Connectivity and the role of the Board in making the connections stronger

The Board is a crucial place to pull up and to look at the collective city levers we could use to work on poverty and a long-term view/action plan for reducing poverty and inequality in the city.	1. The power that the board has to act on poverty and inequality

we have no North Stars in terms of focus	1. An identified lack of a central point

There's a timidity about the board – it has a lack of teeth, and a model which presumes a level of influence – we are a Statutory Board – the Board of the Local Authority	1. Feeling that the Board needs to really get to grips with owning its power, to be the influencer for change

it's our statutory board, and it's not been utilising its capability.	1. being let down by the Board not using the power it has

But what it doesn't have, what it lacks for me, is what will we do. I	1. a call for action

Feeling of disappointment that the real stories are not being told, a lack in communication and a communication plan

How do we know about it, it's a fair point, it's been undersold. The Health and Wellbeing Board more broadly needs to be selling the positives and the stories, we don't sell it very well.	1. The Board isn't doing what it could do. Communication sits with Board and its not delivering on it.
Huge amount of detailed delivery but not in the name of the health & wellbeing strategy, and there is lots of stuff we don't detail very well	2. Not getting into the level of detail on what's happening and linking to what's being delivered that is related to Health
in the refresh we ought to make a bigger effort on all of these lifestyle programmes. Lots of good work going on ACES, Adverse Childhood Experiences, but not has a real focal point – the board could and should be a focal point and add value to it.	3. Lifestyle and the impact on Health, a place for it at the Board and in the strategy in the refresh

There is a need for us to showcase the things we have done really well on, like on reducing Infant Mortality rates, reducing smoking rates, these impact across the whole life course health. We need to talk about these successes on what's worked for the strategy.	1. Letting people know when we have done things well or done things right

Also, feedback from the voices of our population – they are the people we should be listening to, and to advocate for that.	1. The importance of voice and being heard and listened to
My main objection is that if you asked the public about these nine ambitions, they are very aspirational objectives but its not what the public would tell us right now that we should be focusing on – they would say its about food or fuel – these are not at the heart of what they	2. Are we really listening to who we should be listening to and asking what they need – have we got that wrong?

want help with. We need to be asking them what they want to focus on in terms of their Health & Wellbeing needs	

Hopefulness around the opportunities available, but fear to trust that the Board may miss them/may not act on them

There is an opportunity there for greater integration going forward, in the Children's world particularly, in commissioning.	3. Linking up commissioning which impacts on children's health

The Place Based Plan for Health & Social Care –… and the Integrated Care (Commissioning) Board is moving to a South Yorkshire footprint its important as a city that we have a place for Health & Social Care for the next 10 years and to develop a 1-2 year plan on how we are going to work to that vision as key organisations/key partners	1. The move to the SY footprint as an opportunity to plan long term and short term
How is health money going to flow into Sheffield and the role of the HWB Board in influencing how it's being spent in Sheffield as a city.	2. knowing where the money is and where it needs to be

Levelling up: different style of conversation with the government is needed – its currently focusing on the traditional economic areas and there's an opportunity to look at Health & Wellbeing through levelling up and an opportunity to start to have a different conversation	1. Taking Health & Wellbeing through a different lens – tapping into national programmes/funding – to have those conversations
I attended an AWRC Event session with investors from the USA – as a city region event which also had representatives from AHSN (Academic Health Science Networks) where the new Regional Major attended, they are talking about 'Good Health' and the ambition to be a 'Good Health City' – is there a bigger opportunity there to look at the bigger picture and to have a bigger ambition?	2. Tapping into the bigger footprints – linking up/connectivity through opportunity

Anchoring is key – and to have read across those 4/5 leading organisations who have estates very large workforce who buy into the local economy for goods and services, who are big	1. Lack of clarity by the Board on being aware of, or seeing local anchor organisations and the power and influence they have on health in the city

employers – SCH, STH, the 2 Universities. How are they helping us to think about successful transitions of children of staff and in them pushing forward the HWB Strategy? I don't think we have been clear enough about those opportunities.	

Feeling of separateness, disconnect, and lack of inclusivity

I don't know whether information is successfully and routinely collected and reported on Physical Activity, and Move More I've never been involved in that, but it should happen.	1. A feeling of disconnect in knowing what's going on at the board, and wanting to be part of the board
Physical Activity is a big part of the 9 ambitions. It's such a significant role but no one ever asked me to summarise its impact.	2. A heartfelt desire to be part of the board, and feeling outside of the board

Probably one of the failures of the HWB Strategy is that it feels separate it's not fully linked to the other strategies	3. Lack of connectivity, standing outside of, feeling of separateness
The Levelling up Fund and the Housing strategy – any organisation for Health & Wellbeing needs should be part and parcel of it – we can't achieve it if it's a stand-alone strategy	4. A need for greater connectivity if we want to make effective changes

The Local Area committees have just completed their Community Priority Plans on what's most important to them as Communities to focus on over the next 12-18 months, which they have pots of funding for. Aligning the HWB Strategy Review with the LAC Priority Plans is important	1. An awareness of the role that LAC's could play with the HWB Strategy and delivery if there was a read across to each other's action plans

Early Years has been the poor relation –those first 1001 days – issues in childhood develop into issues in adulthood – there is evidence to support this – the whole life course – we have neglected Early Years as a board.	1. Children being overlooked by the Board

Needs to be a national/regional/ and local response – we can't solve this on our own as a Local Authority.	1. Acknowledgement that there are problems which Sheffield needs to call on others to help with

	(inter-dependencies and inter-relatedness)
Some of it in not in SCC's gift as a stand-alone to deliver against these ambitions	2. The interconnectedness to help realise the delivery of the 9 ambitions /the life course approach

There needs to be more of a connection between the HWB Board and the Health Protection Committee. We need that connection between Health Protection and the HWB Board and strategy to be stronger.	3. Health Protection and connection to the Board
It fits across all of the ambitions and affects people's health and their life expectancy. It would be good for the Health Protection Committee in terms of Governance to be under or to feed into the HWB Board – that would really help Health Protection	4. The part Health Protection plays in people's health and being able to report into the Board

I was involved …in the HWB Strategy at the beginning, when the strategy was first shared – at that time there was an expectation that we would be a partner, but we are not on the Board, so we don't report back on this ambition.	1. Disappointment at being excluded

Inclusivity and Diversity – the Board is not diverse	1. The membership not being fully representative

Strong feeling of desire and need to see the Board demonstrating commitment through action

If we are committed to the life course approach, then why don't we intervene earlier at those key transition periods and the enabler of whole systems working and a real commitment to the life course	1. An ask to follow through on what the strategy says its committed to
translating that into action across the city	2. A desire for action, not just the talking, the rhetoric of the strategy

Having the words isn't enough. You have to operationalise it.	1. A need to see a change from words to deeds

Have we really done everything we could do internally in the city really shifted resources from one area of the city – there's a really harsh conversation to be had around redirecting the level of investment around Dore for instance, to flow into Darnall? We are doing bits of work and I see real attempts to shift things that way, but they are really hard to do.	1. The reality of inequality and what that would mean in terms of action, which would be a tough shift

THE HWB Board – we are not making the most of its statutory function and what it could be actively doing – the challenge/the detail/ the discussions and really driving the city forwards – that could be the HWB Board.	1. The board that is needed versus the Board that has been

Strong feeling of desire for commonality, a shared common purpose

If you are doing a HWB Strategy, it shouldn't be seen as a group of different projects and programmes – it should be the way in which all partners deliver their work and the have the outcomes. Its about having a 'common purpose and common approach'	1. Fragmentation and separateness versus togetherness and feeling of being united in a shared purpose
It should be the right thing to do for every organisation as core group for HWB and not necessarily the best thing to do for their organisation.	2. The Board as a core homogenous group who do the right thing
Probably should all collectively, the strategy should mean everyone has the same priority which they focus on – and to do 1 thing –	3. Commonality of priorities
we all agree as a Board of partners to use our resources in a way that achieves good health and wellbeing.	4. Commonality of sharing resources for a common purpose
There are definite crossovers between the HWB Strategy and the Poverty Action Plan	5. Repeated worry about poverty in our city population and being connected into that
It's the whole city's responsibility	6. The collective/collegiate responsibility – not for the Board on its own or the strategy on its own

Needs to be a national/regional/ and local response – we can't solve this on our own as a Local Authority.	1. Acknowledgement that there are problems which Sheffield needs to call on others to help with (inter-dependencies and inter-relatedness)

Some of it in not in SCC's gift as a stand-alone to deliver against these ambitions	2. The interconnectedness to help realise the delivery of the 9 ambitions /the life course approach
Its about connecting up – working as a system	1. An understanding of the central strength
Recognising collaboration and connection can result in a bigger lever – we can have more impact. If we pull on the levers we have always pulled on we will get the same results	2. Where the strength/power lies
It's a key – it's about equity of health and giving people/empowering people/nurturing people	3. Strong desire for equity and valuing people, putting people at the centre of the strategy

Slowness of change in the housing world and to get into that housing & Health agenda. When did we get the DWP to come to the board to speak about Employment and our local situation	1. Frustration at the time things take and not connecting with the right government office, for them to hear what's happening in Sheffield

For the Board and its partners to collaborate with a purpose.	1. Working in unity for a common purpose

Strong feeling of worry (anxiety) about the cost-of-living and poverty and connection to people who are on the welfare system

The Cost-of-Living increase is focusing our minds and the link across to the health world	4. Where we are now – the current state of play – the national picture /local impact on our population's health
We have a very fragmented welfare system, system of support, benefits system, which people don't know how to access that system until its too late and they are in crisis, or close to crisis.	5. People in crisis, not knowing what they need to know

inequality exacerbated by Covid. Have we successfully understood and targeted support to those communities which are under-served and in the worse conditions for health & wellbeing.	1. Concern and questioning how we are serving those who need it most
Do we/working in specific communities in the city and communities of interest and are we sufficiently engaged with leaders in the community and with their lived experience in shaping how we tackle that	2. Questioning the genuine level of engagement with our communities and valuing their experience, valuing their voice 3. The values of the HWB Strategy and the Board

Poor quality housing and homelessness is a major contributor to good quality or poor-quality health. It hasn't had the attention it needed and now the Cost-of-Living crisis we need to work together in the city to look at this.	1. Looking at it from the lens of housing and homelessness, a desire for fresh attention.
how do we support people to live healthy lifestyles when they have significant hardship	2. The dilemma

A lot of the food work is about social injustice and poverty …and the Tobacco Strategy has poverty all the way through it and the new Food Strategy will have social justice and fairness – everyone should have access to a healthy diet, but they can't because the money isn't there, poverty is there, and these should be the focus for us all as organisations	1. Worry about the impact of not having enough money, the poverty trap and not having enough to eat as social injustice
Children and food poverty there is evidence to show that it impacts on their life course and life chances if children live in a food insecure household	2. What is known (knowledge/truth) Food insecurity and the effect of that on a child's life

The Board has to be a lever, for the cost-of-living crisis	2. Feeling of urgency and what the board should be doing

Need greater recognition of the context in where we are operating – disparity, the poorest hit, marginalised geographical racial and other communities of identity and the pandemic has exacerbated inequalities.	1. A feeling that things are not being seen as they really are, and the people hardest hit

it should be about inequalities in everything, about Poverty. To reflect – what's the issues about inequalities here, if we began with that question in everything but I know that's such a hard shift to make	1. Where the real focus should be
Our key anchor organisations in the city, they need to talk internally and to ask what as an organisation are they doing on poverty and inequality, on employment	2. The big city employer's responsibility on tackling poverty in the city

My sleepless night is Poverty and the opportunities for Poverty	1. Poverty being all consuming

Summary of Emerged/Discovered Patterns:

- Impact of Covid on people/communities/the city's health
- Feeling of isolation/separateness/disconnect from the strategy, the strategy delivery, and from the board
- Worry about the impact of poverty and inequality on 'healthy life expectancy'
- Worry about the Cost-of-Living Crisis and those most in need
- The Board and how it could be as the lever for action/direction/'clout'
- Unsureness of what's being delivered/disconnect – gaps in communication from and to the Board.
- Voice – whose voice is represented, is it inclusive? Whose stories are we telling/not telling?
- A call for less rhetoric more action by the Board and the Strategy – where is the action plan
- Call for focus – defined clear agreed shared focus and commonality of purpose
- Change needed – let's do something different – left of field, the pointy end, being courageous

Reference: Braun, Virginia and Clarke, Victoria (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101. ISSN 1478-0887

Appendix 2:

H&WB Review 2022 – Interview Analysis and Methodology

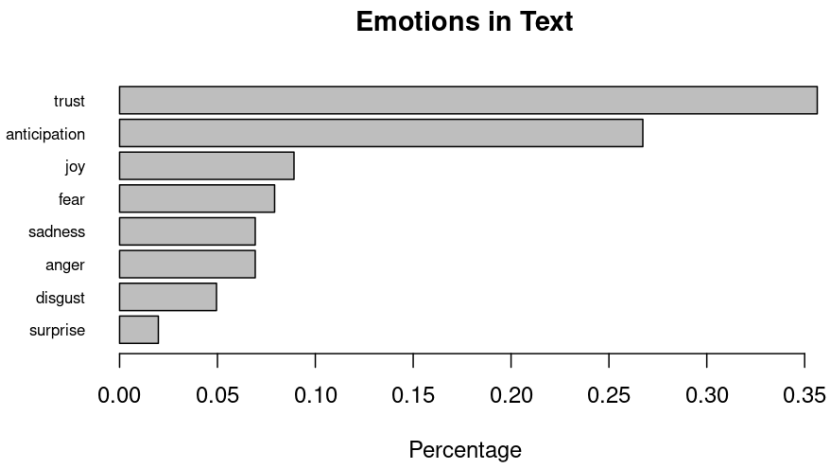
- *Emerging themes and subthemes*
- *Evidence/quotes*
- *Connections between themes/interview responses*

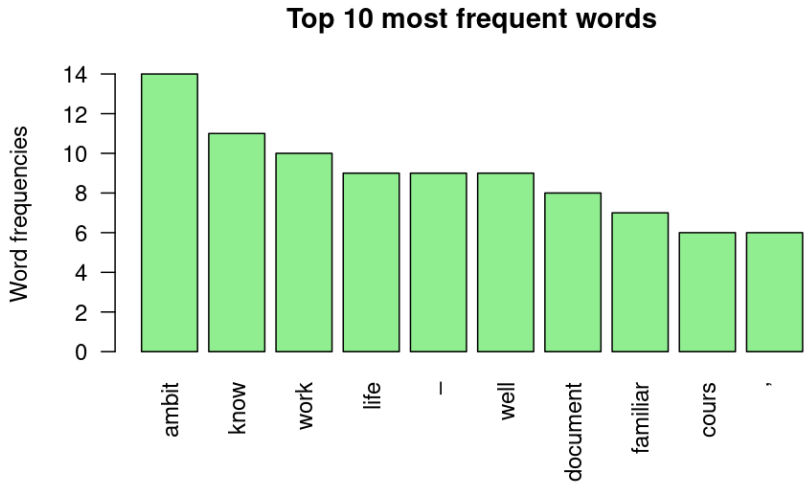
Method:
21 interviews, all of which were analysed using thematic analysis methodology, implemented by two researchers. Prior to thematic analysis all transcripts were ran through R using a text analysis methodology to create initial emerging themes. These themes derived from most common words and sentiment analysis.

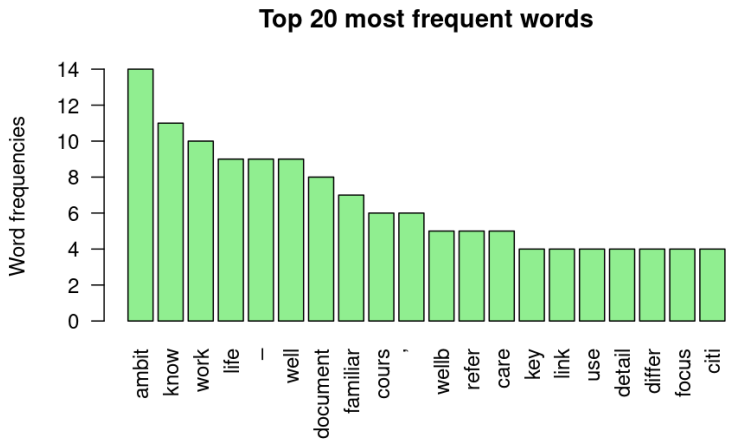
Key words from themes: Covid, isolations, inter-connectivity, voice, poverty, actions, focus and communication. Whilst there is still confidence in the board's ability, there is a need to a refresh of its structure and the strategy. Overall, the 9 ambitions do not need to change.

Main themes:
Covid-19 has seriously hindered motivations, momentum and morale. It appears that the HWB activity was more susceptible to this due to its fragility prior to the Covid-19 response. There is a large focus on measuring success and developments and that the lack of these negatively affects enthusiasm.
Responsibility and membership, especially that of the key members, was a theme which appeared to effect how others identified with the board and their commitment.
Tying in with the previous theme connectivity, communication, (inter)connectivity and working together is a huge umbrella theme which emerged throughout and had a relationship with all the other themes.

Question 1: **How familiar are you with Sheffield's current Health & Wellbeing Strategy?**







Phrases such as ‘not very well’, ‘aware’, ‘vaguely’, ‘moderately’, and ‘know of its existence’ were used a number of times. There appears to be a definitive spilt; people are either very confident with their knowledge of the HWB strategy, the 9 ambitions and its applications (SB2 and GHL) whilst others are knowledgeable of the ambitions which relates to their job role but their overall knowledge in the details were limited, “Not very well at all. I know about the 9 ambitions as a group and I know my ambition, sits as Ambition 5 in Living Well. If you asked me about Ambition 5 and how that links into the HWB for the city I could tell you.” Others stated that their knowledge came from, “people refer[ing] to the HWB Strategy a lot”, however another interviewee stated that “I’ve look at it from time to time, when writing cabinet papers where I wanted to refer to the HWB Strategy”. Whilst the information and resources are available, they are not be used and promoted effectively.
One interviewee stated, “I know it very well. I have had an immense part, was Chair of the HWB Board May 2019.” Whilst another individual said, “I don’t know how much it achieved its aims – it’s difficult to measure that.” There are several arguments here, firstly is it a matter of measurement, if so can this be achieved, or is it rather a lack or individuals merely sharing their success and achievements with one another. Secondly, by this argument it is fair to assume it is the responsibility of key figures in the HWB to share knowledge, highlight success and promote interconnectivity.

“Not very well at all. I know about the 9 ambitions as a group and I know my ambition, sits as Ambition 5 in Living Well. If you asked me about Ambition 5 and how that links into the HWB for the city I could tell you.”

This statement, similar to those previous, it highlights how the individual’s knowledge of the 9 ambitions is limited to what is necessary for their role. It could be argued, stemming from other feedback, that the opportunity to learn about the 9 ambitions and the HWB strategy and share with on another has been limited as a result of Covid-19 and how that in response effort priorities were understandably and uncontrollably shifted.

Effects from Covid-19:

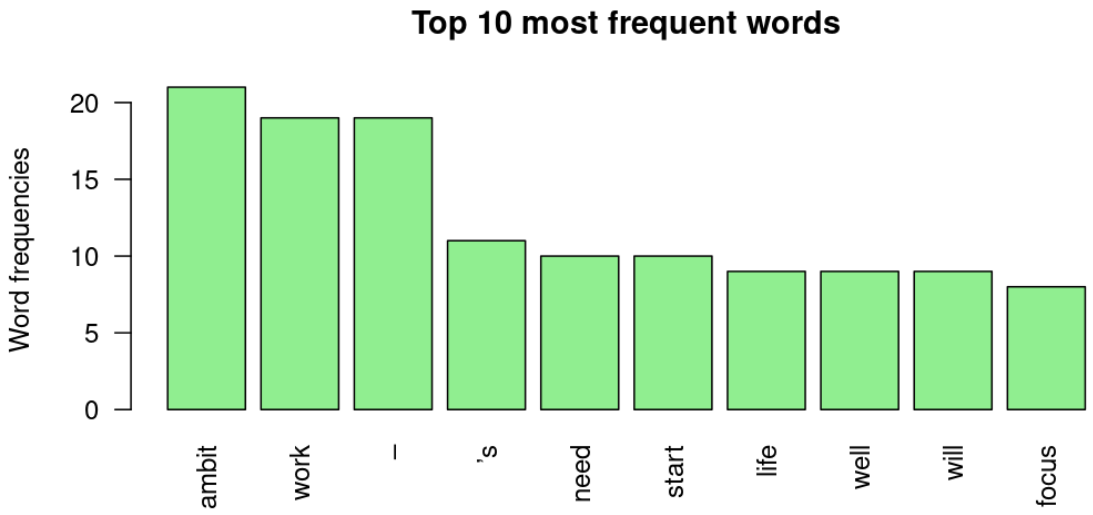
“For the past two years we have been very Covid focused”

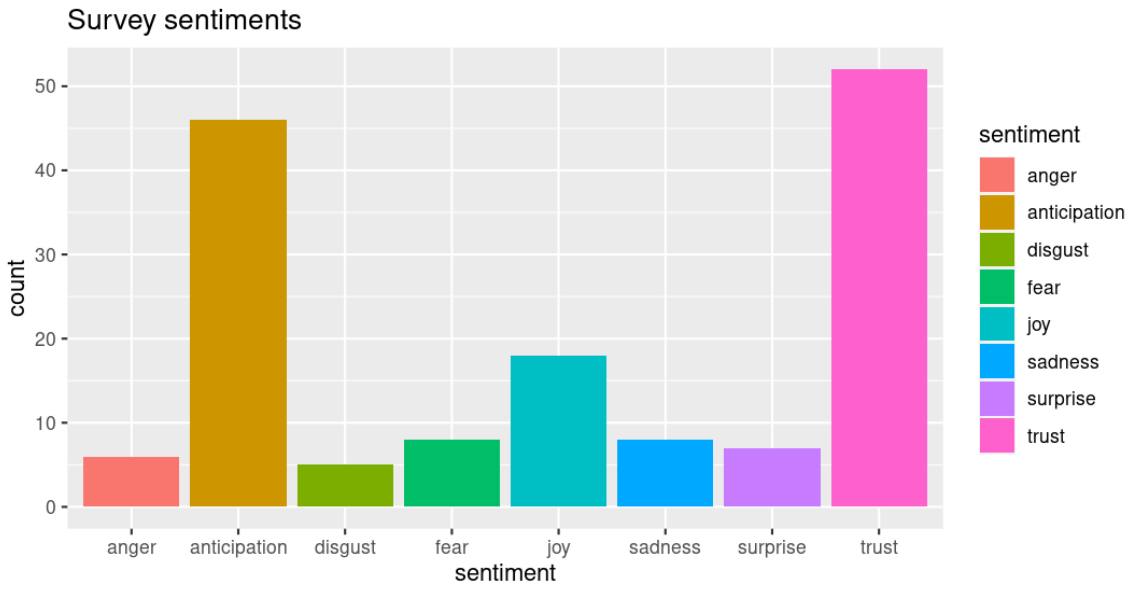
“I am familiar with it as a key document but not in any detail over the past two years largely because of working in the Public Health Team and we have had a 100% focus on the Covid Outbreak Response I haven’t done any work on it. Haven’t been able to contribute to it. But pre-Covid yes on the different themes and with a lead responsibility for one of the themes.”

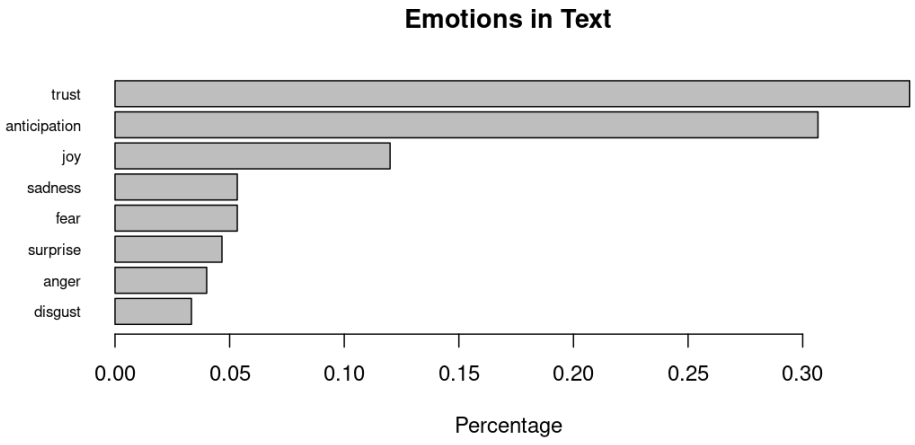
“We have a lot of projects with a Health & Wellbeing focus which impact on it. May 2020 we were due to go to the Board to report on Employment, but Covid happened, and the board was cancelled. There has been no correspondence between the HWB Board and us, no communication on Health & Wellbeing and how that links into the work we do.”

It is evident that any opportunity for growth and development within the HWB has been greatly hindered by Covid-19 responses, which is to be expected. However it appears that this only exacerbated pre-existing weakness in regards to interconnectivity and knowledge.

Q2 "2. **How much has it been a key part of your responsibility/role to take it forward? And/or to take The 9 Ambitions forward?"**







Throughout the data gathered from this question supports a lot of what the text analysis reported. Interviewees highlighted confidence in the HWB and the ambitions however were often faced with continuity problems, lack of progress and lack in confidence in regards to where their position and abilities are used.

"Yes, it's the right ambition and yes, it's in the right area in Starting Well. I like the life course approach of the 9 Ambitions – it makes sense, the flow is good. We don't really have a lot of input into the strategic approach on. Its going to change quite a lot, and the Council Leads/Exec members are no longer Exec Members. It's all up in the air. But I still like the principle of Ambitions 1,2,3 being together – they still feel very relevant."

"We have done well. But Starting well & Transition to Adulthood, Ambition 3 – it hasn't progressed.. It should be a really strong focus for us, and our most vulnerable children have not achieved this ambition and continue not to achieve it."

"What did that mean I did differently? Nothing. My ambition was scheduled but never came up."

"Its high level to give context for Health, but it can't cover everything in Health."

The focus and direction of the HWB was also queried:

"Not really in terms of discussing it – the Board is very clinical focused except for one which was on Education which was much more holistic, with a range of contributors, and Health it needs to be holistic. We need to talk about good health and not on disease. "

The 'holistic' nature, or lack there of, of the board has strong connection with themes present throughout the report in terms of communication and interconnectivity. Could the change in direction/focus, which this individual talks about, have naturally occurred from Covid-19 response, however, refocus will need more attention as it might not happen as naturally and required greater focus and effort – this could be something influencing the apprehension seen in the text analysis. When reflect on previous example this individual said, "We talked about the broader context, and it was lively and more engaging. It needs to be more holistic", this really homes in of the idea of membership and its relationship to support and promotion within the HWB. This factor is seen throughout:

"There needs to be more of a connection between the HWB Board and the Health Protection Committee."

"My work is not overtly connected to this strategy. I'm a bit unclear as to how the Public Health Strategy is linked to the HWB strategy."

"If you were to give this document to someone externally it feels more like an information HWB Board."

In addition to the idea of reflection, and people looking back on positive factors, one individual stated, "I went to the Board 8-9 years ago, when we used to have a Food & Physical Activity Board that fed up with the HWB Board, but it never really worked". It seems as though previous experiences, positive or negative, have generated feelings of apprehension, which are then being reinforced by a lack of productivity, or 'measurable outcomes' and fuelling current doubts. All of which will affect how people respond and interact with the board: their interconnectivity and membership.

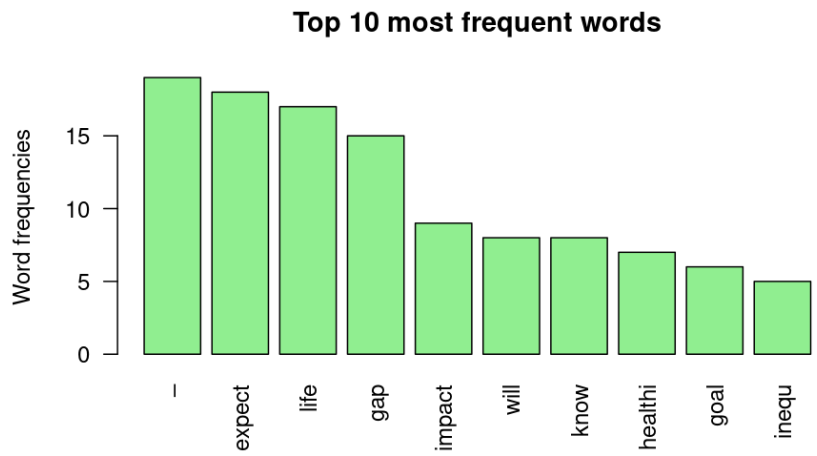
Representation throughout the board was also touched on,

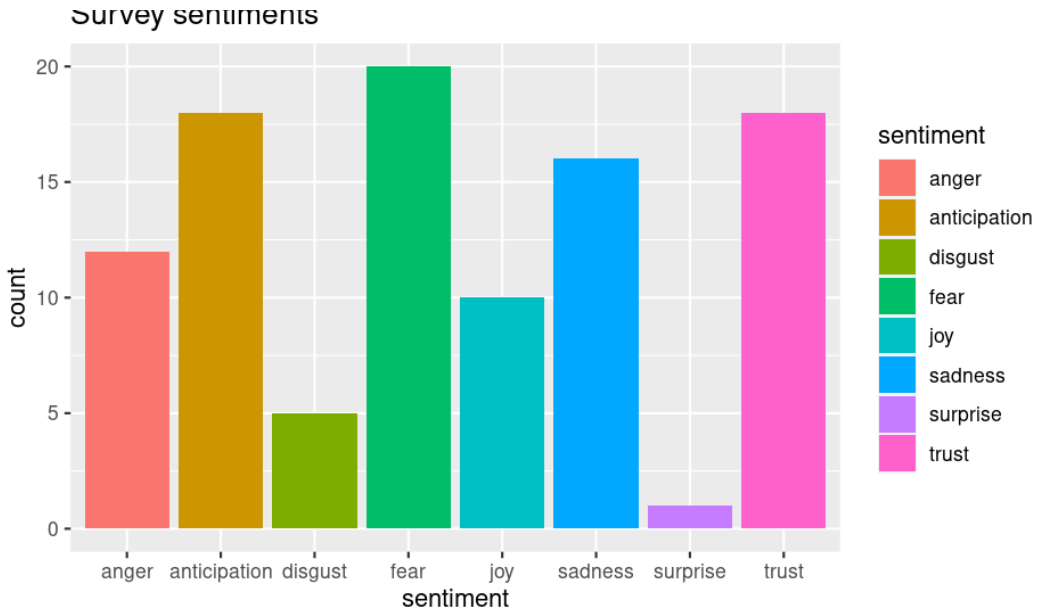
"we don't have anyone from Communities who sits on the HWB so we don't have that conversation. The best person to represent Communities on the Board is Lorraine Wood. There is something about the membership on the board and having the balance for the 9 ambitions."

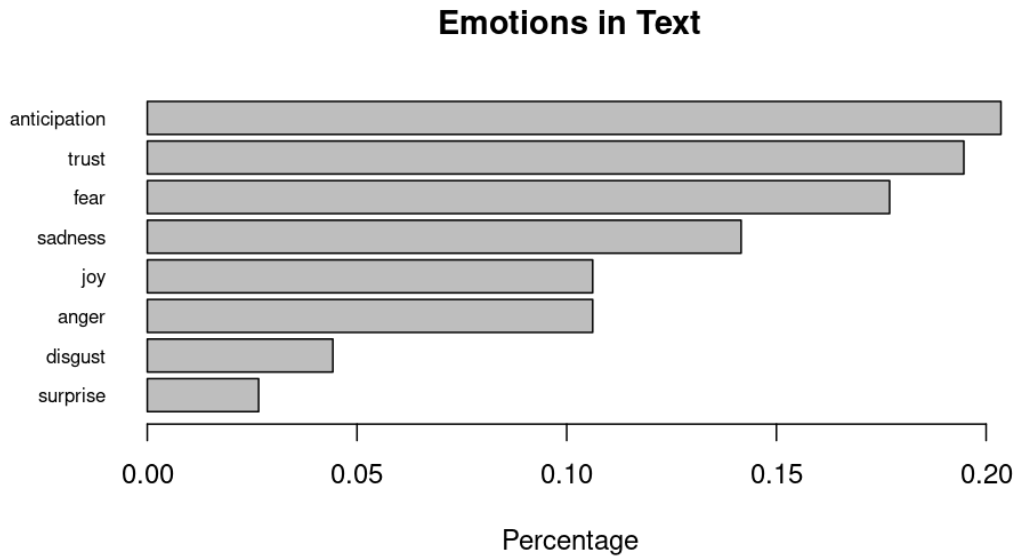
This is a key piece of evidence, especially as throughout this research we failed to interview someone who could represent transport, a key area involved in the 9 Ambitions.

Q3: "**Have you been able to contribute to the HWB Strategy and on the delivery of the strategy?**
“But with Covid and the PH response to Covid this has been a barrier to remaining engaged”
Not much data gathered on this questions however this quote above strengthens previous points regarding covid-19 and to what extent it hindered morale, engagement and productivity of the HWB.

Q5. Life Expectancy & healthy Life Expectancy







Most data in from this question follows on from previous themes, interconnectivity, communications, resources and effects of covid. From the text analysis it was clear to see that there was a lot of fear and worry in the responses. Through the TA these reasoning behind this became quite evident. One Interview said the following quote which highlights many of the key themes and reflects what others have also said,

"I think it won't have got any better, but not because the HWB Strategy hasn't been successful or delivered, there are lots of good pieces of work going on, but on national external factors which have impacted on the strategy and its delivery – namely, the impact of Covid, the Cost-of-Living Crisis. It won't have narrowed the gap"

Another said,

"How many people know that our overall goal is our No 1 priority is to reduce the gap. I don't think people know that. Not many people know that's our goal our No 1 priority."

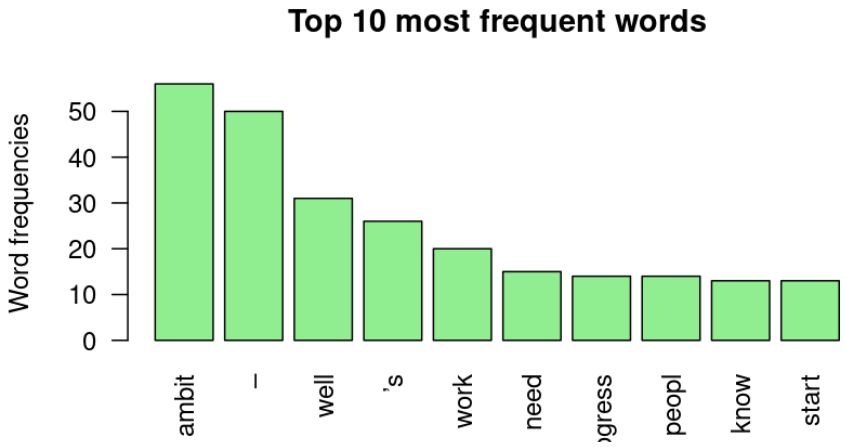
This point was strengthened as another interview proved their point,

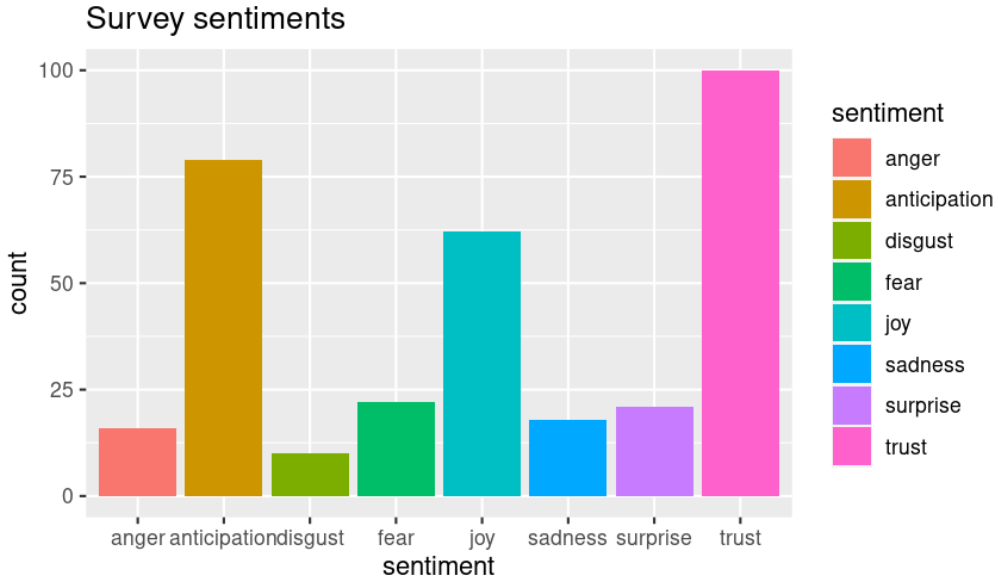
"What does the data say about Life Expectancy and Healthy life Expectancy, I would like to know?"

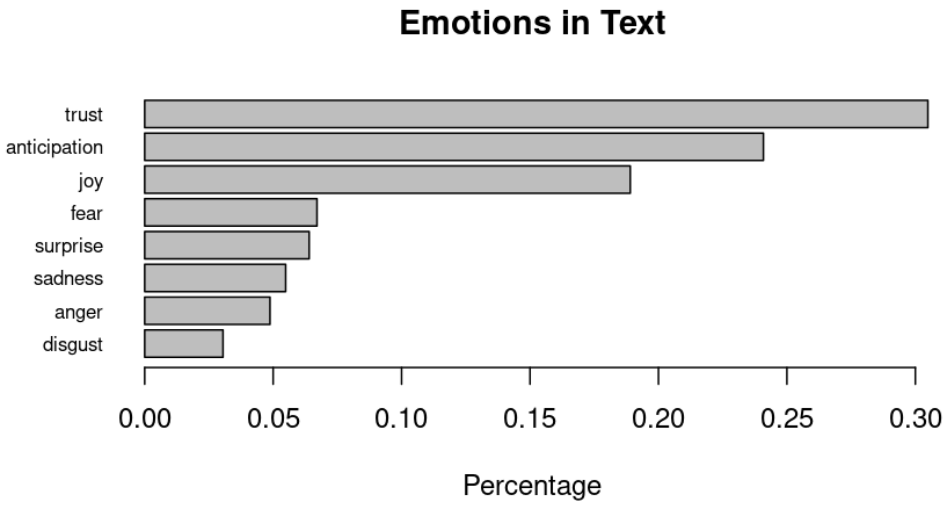
Communication here seems to be a key theme, however resources and how they are used and how they have been effected by Covid-19 has also been a key point of discussion and theme.

"Life expectance – no we haven't. The reasons: Political – to really focus on the gap we really need to do targeted work and at times this has been politically challenging. Covid and its impact – that created challenges not only by increasing inequality but on Schools the impact on teaching and learning – as stakeholders we were distracted away from the Ambitions and the HWB Strategy to Covid and responding to it."

Q6 and Q7: **How well have we delivered on our 9 ambitions? How well has your ambition been delivered on?**







The data from this question highlighted a lot of data and thoughts on the refocusing of the 9 ambitions.

"My main objection is that if you asked the public about these nine ambitions, they are very aspirational objectives but it is not what the public would tell us right now that we should be focusing on – they would say it's about food or fuel – these are not at the heart of what they want help with. We need to be asking them what they want to focus on in terms of their Health & Wellbeing needs."

This highlights focus of resources. Does the use of the word aspirational highlight the idea that it is not necessarily achievable?

I regard to resources and measurement there was quite a divide, whilst some people stated "We are clearly not achieving what we set out to achieve and there are national pull factors, and because of the size of the challenges as well as, as a Local Authority Board we hadn't got a pot of money to tackle the underlying factors", and clearly wanted, or need, evidence of progress and success, Other said things such as,

"It's hard to talk about success for Ambition 2, with School attendance, it's an issue for Sheffield and the weakest part of our data sets, from an education perspective post Covid" and "large part of 'fulfilling' is subjective to the person making that choice – that's hard to measure?"

"Transitions whole plan on children with SEND and multi-agency approach and the voice of children and young people and families which isn't included enough either. These are massive, and the board hasn't agreed its key focus on these"

It is apparent that there are mixed feelings towards the 9 Ambitions, and whilst no one strongly thought they should be scrapped, or anything that drastic, from these quotes there is obvious apprehensions and a desire/need for change.

Similar to the other questions, the following quote add to the themes of connectivity, communication and consistency, "huge amount of detailed delivery but not in the name of the health & wellbeing strategy, and there is lots of stuff we don't detail very well or co-ordinate, or link sectors together there's a whole bunch of constraints too." In addition, another interviewee responded with, "Where are they owned, who are the leads? There's no action plan for the HWB Strategy. It doesn't feel like there's much involvement from the HWB Board".

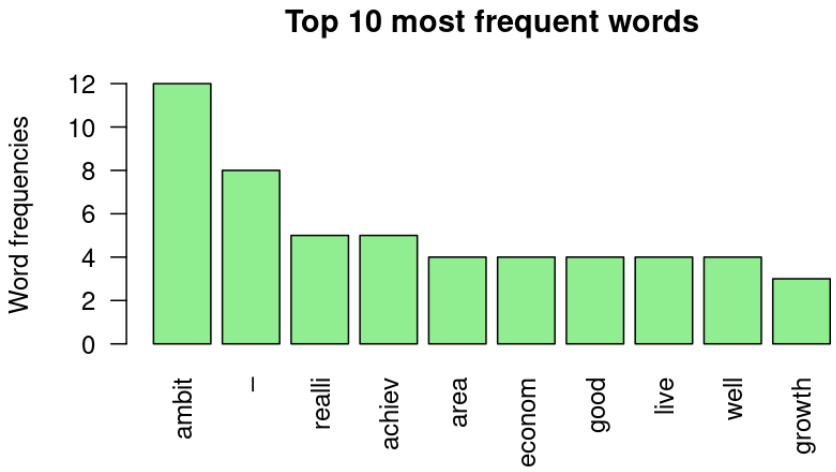
"Yes, it's the right ambition and yes, it's in the right area in Starting Well" - Does this suggest that other aspects may not be in the right ambition, or could it be a consequence of "maybe that leads you to think the ambitions are too big", as an interviewee stated. There is also the idea that some areas are being forgotten and hence failing, "the transition to adulthood for Young People with SEND, I appreciate it's a small cohort within young people transitioning, but it's the one recommendation from the LA SEND Inspection, it's the one we haven't made progress on. I appreciate it's a sub-section of the whole cohort. I don't know what the level of progress would be or what we might expect it to be." Responses to this question also highlighted tone of hopelessness – influenced by external factors previously mentioned by other interviews, in this case it is the cost of living crisis, in others it has been covid.

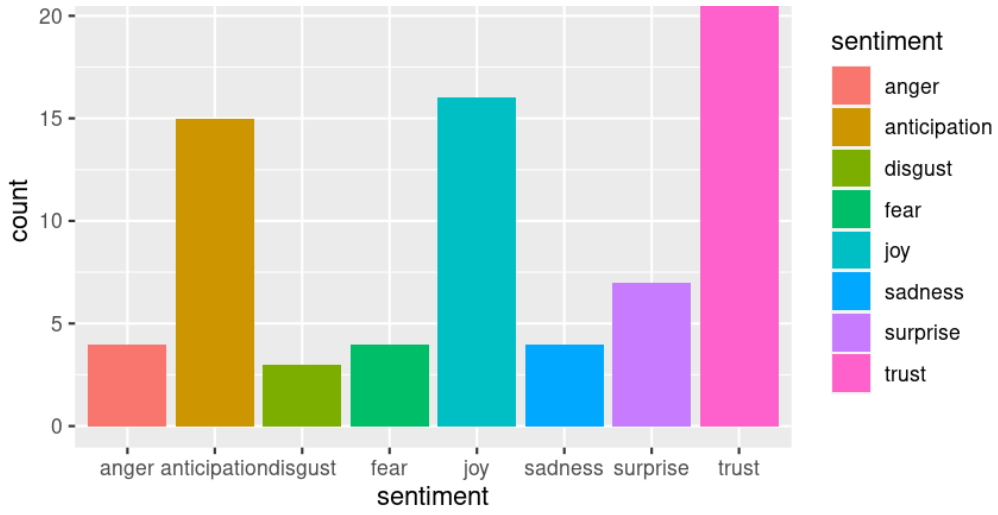
"People Living Well: Ambition 5: Cost of Living - I don't know what we could do in any way to have a ballpark improvement to mitigate the Cost-of-Living crisis. I wonder if by having high level stuff, we have set ourselves up for failure. Most of these areas have service plans, and good people trying to achieve them."

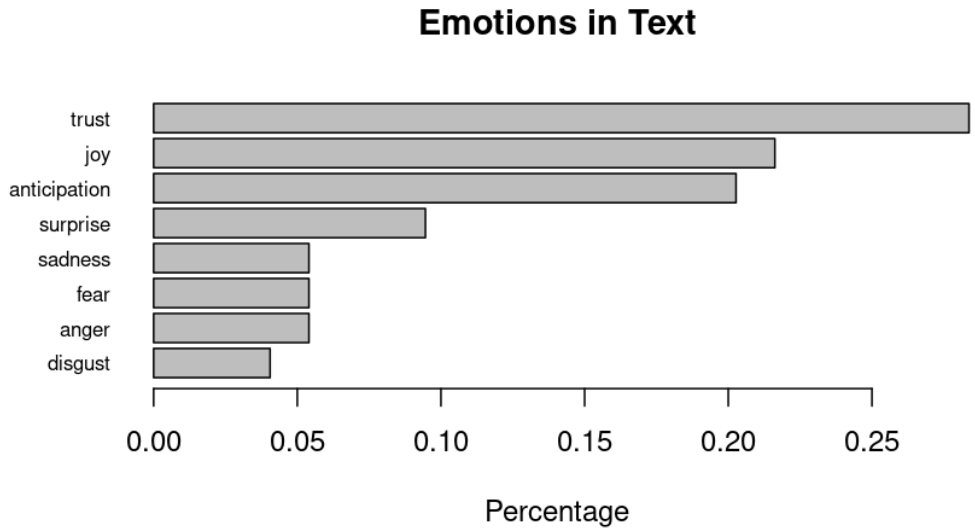
Similarly, "That's the Golden Thread across everything. Some of the other nine ambitions: to look at the nine, to take stock, to look at what we have done, and to look at what are the gaps, where do we need to prioritise next." Almost like movement has come to a holt, and there has been no progressions to measure (coming from other previous comments) – this will affect morale and apprehensions, that desire and need to get things up and running again but there is possibly a level of hopelessness'.

The following quote strengthens points from previous questions, “Ambition 5: the pandemic has had an impact – it’s about engagement – it needs a refresh, and we have a very clear idea of what’s been delivered so far, a huge amount of work has gone on, and to look at what we are doing well “, another interviewee furthered this by saying, “Time to take stock though and to bring back to the board to see where the next iteration goes. Sometimes difficult to iterate and to monitor”.

Q7 **What is already in the strategy (the 9 ambitions) and what is happening in each of the areas current state of play and main recent developments? In any of these ambition areas there is a whole range of activity. Much of it is just part of routine business of one of more of the organisations or constituencies who make up that area.**

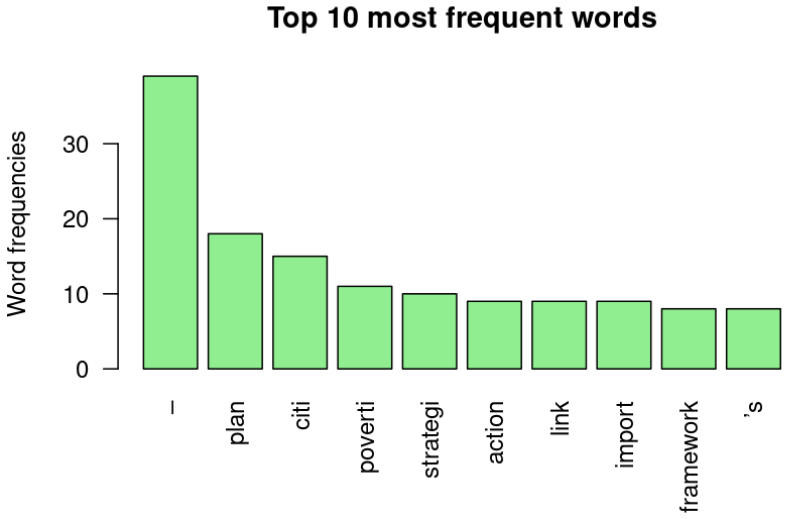


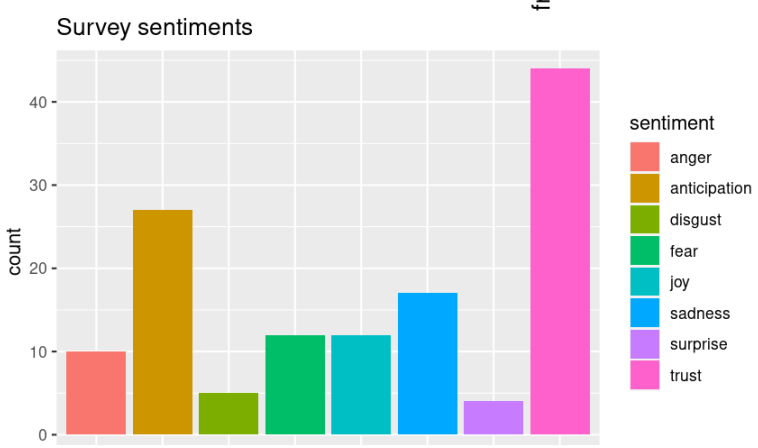


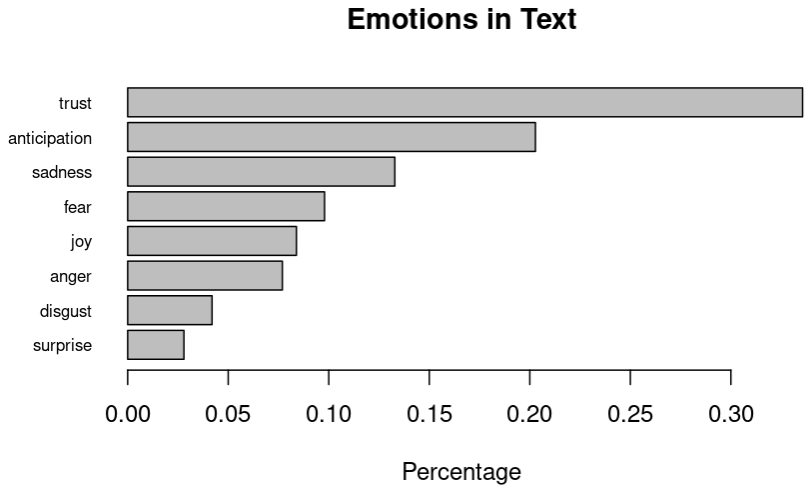


Questions 8?

Q9 **What strategies already exist and are being implemented within the scope of each of the 9 ambitions? For example, within the ambitions: Ambition 1 – what is in the box around the First 1001 days, the Infant Mortality Strategy, school readiness. Ambition 4 on housing there will be on homelessness private rented sector, affordable housing, hazards in homes, fuel poverty, building the right number of homes. Ambition 9 – End of Life there are three main strands – compassionate communities, clinical pathways, business intelligence. Each of which has sub themes.**







The responses from this question highlighted that people thought you “should be able to draw a clear line between each ambition and each strategy plan”. The use of the would ‘should’ highlights that this is currently not the case. And again, the need for a better focus was touched on,

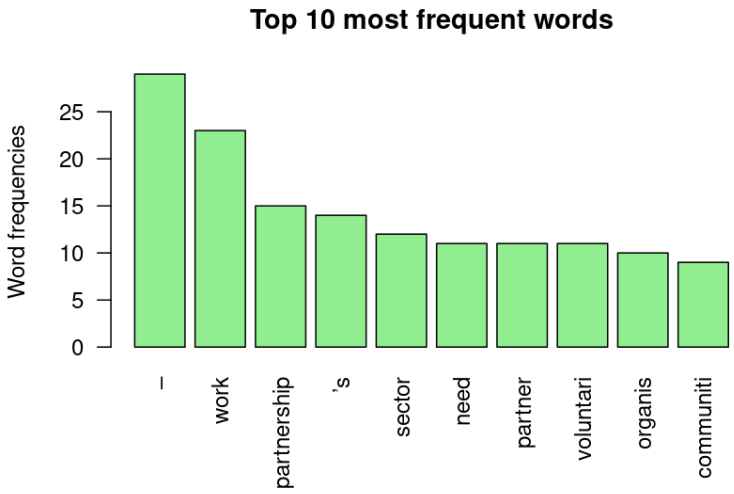
“Activity and exploration – opportunity to dive into data and insight and developing action you get real energy and where you get the lever are – a strategy should be driving that focus”

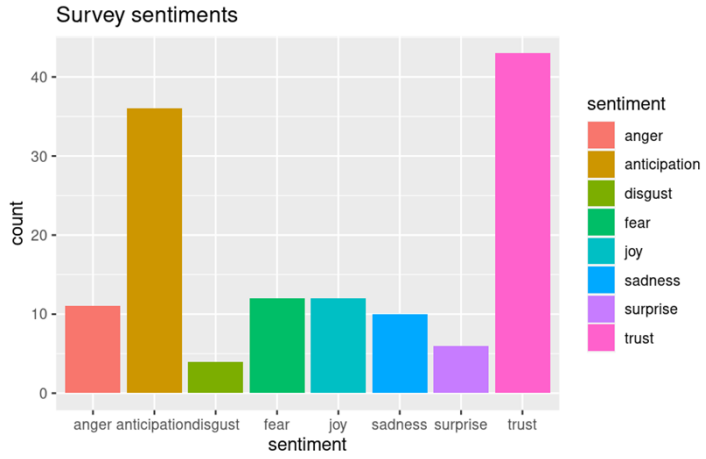
Others thought there was too many strategies “sat on the shelf”, several main points arise from this. Firstly is it because the connections are not clear and that is why they seem to be ‘sat on a shelf’, is it because, like in other points, the outcomes are difficult to measure and hence may not be shared. If this was the case would people see the purpose of the strategies as they good see clear use and benefits of them. Secondly, similar to other previous points, could there be connections which are being missed due to a lack of communication and interconnectivity.

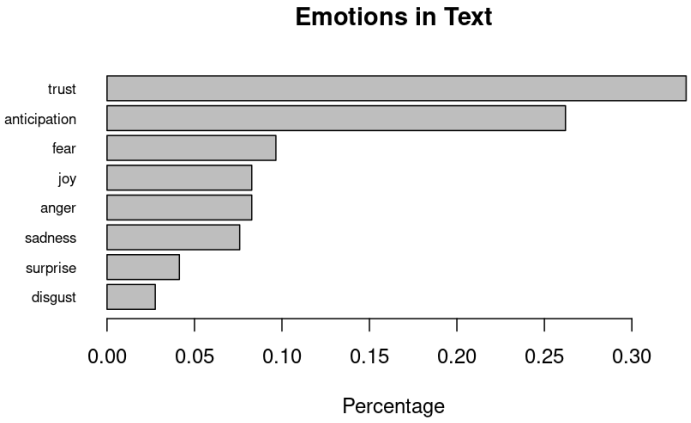
“Every organisation individual corporate plan should acknowledge and link to the city’s HWB Strategy. Do they?” – this will not be achievable if there is weakness in the membership and leadership of the board, similar to that of the promotion of the ambitions within the board, there needs to be a front person; a key driving figure.

*THIS A LORRAINE QUESTION

Q10. What is the broad ask of the city in terms of **partnership working to** improve the trajectory of key outcomes? What can you or your organisation do to improve this cross-sector collaborative trajectory?







This data really stresses the faults rooted with the lack of communication and collaboration within the board,

"All our plans are Multi agency plans and can't be delivered without that approach – it's a whole system delivery approach and not an organisational approach. We need to bring in the voluntary sector and to build on their work with communities and to build on community resilience – we are not making the most of the assets in the voluntary sector"

"Information sharing – we need help with cross-sector. Assets are not fully utilised"

"Yes, we need to improve it – each ambition is led by a certain partnership organisation. For example, Housing is SCC led and comes with issues – we have struggled and failed to get an account of what SCC Housing are doing and creating spaces to work with other partnerships. E.g., Commercial landlords, Think Tanks, Advocacy organisations – creating these partnerships are important. Other partnerships feel successfully jointly led, between the Local Authority and Health Care and Support."

There was a varied response in regard to the reasons behind the lack of interconnectivity, some highlighted that individual people and sectors were at fault, where as others shared the thoughts on resources. 'measurement' again came up, possibly highlighting that ubiquitous theme that as there is no 'proof' or success or development, people don't know what they are working towards, are who they need to collaborate with to help develop projects.

"The Voluntary Sector – its hard to engage you either get those ones who are consistent in engagement or smaller organisations who don't have the capacity or the capability and feel on the fringes. The voluntary sector and communities need to be better at working in partnerships themselves. They need to do more collectively about working in partnership and to be open and honest about their collective endeavours that would help the delivery of the HWB Strategy and its ambitions"

"We struggle to get/link with the NHS to get the right people to do things differently and that's the key lever which the board has – the power to do things differently."

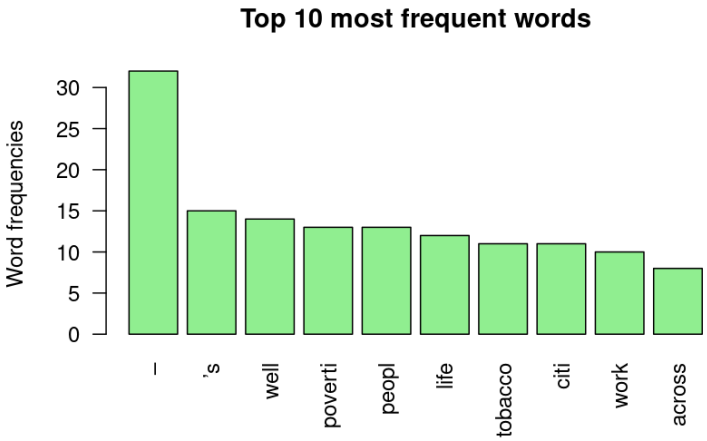
"There are no clear actions or action plans… And to have measurable Delivery Plans"

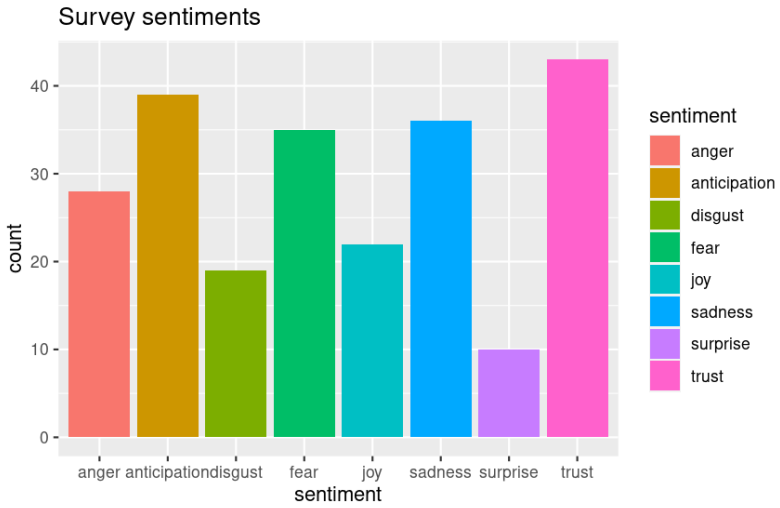
The following quote highlights previously stated points. Firstly is that of communication and collaboration, and secondly the apprehension of large changes and developments. Possibly greater apprehension if people are aware of the existing faults which may affect future and current developments,

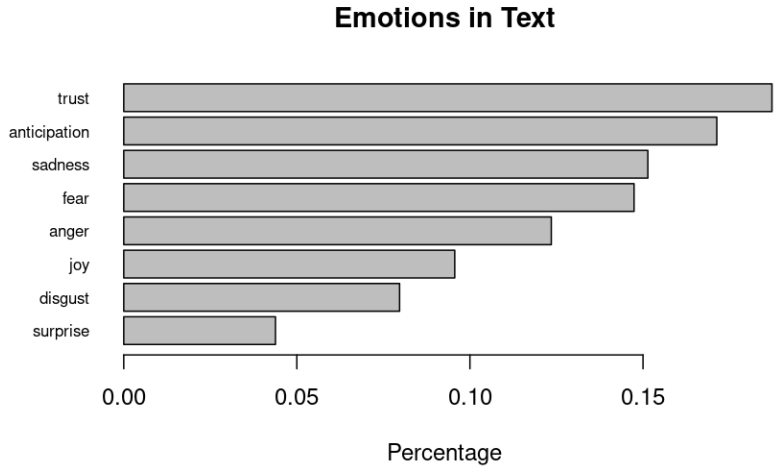
"The Place Based Plan for Health & Social Care – as the CCG is coming to an end and **the Integrated Care (Commissioning) Board is moving to a South Yorkshire footprint** its important as a city that we have a place for health & Social Care for the next 10 years and to develop a 1-2 year plan on how we are going to work to that vision as key organisations/key partners – i.e.. Hospitals, CCG, SCC/ Voluntary Sector and to bring all their plans together and for joint commissioning intentions and the outcomes framework for Health & Social Care. It's not written yet, currently in discussion stage, it will certainly reference/link to the HWB Strategy for Sheffield. It's an attempt to bring together all these plans to be 1 place-based plan for Sheffield"

This is strengthened when another individual said, "I am not a member of the board, but my impression is that there was a lot of establishing relationships, but with lots of changes over the past year".

Q11 **Thinking about the big areas that are not explicitly named/checked within the HWBS but contribute significantly to health – e.g. Smoking, Food, Activity, Health Protection, Poverty, Economic strategy, where is their place in the HWB Strategy Review?**







In the responses to this question the focus and appropriateness of the ambitions, strategies, resources and behaviours was often discussed, “What things do we need to do to improve say diet?”. And once again topics of interconnectivity, one individual also said, “and these should be the focus for us all as organisations”, this was in reference to poverty and healthy diet, access to good food and tobacco control. It is suggestion that whatever the HWB focus may be, it needs to reflect the current social and political status and changes within the city. The only way to keep this up to date and maintain purpose is through communication – something which we have seen mentioned throughout all of the questions.

There were also several suggestions for future change and application with a large focus on connectivity:
“Physical Activity sits outside the Local Authority in the National Centre for SS, and it would be good to connect the National Centre Board which sits alongside Sheffield’s H&WB Board and to strengthen those connections, to connect up what’s already there, to make it more robust”
“This is where I would value having the help of the Board, with the HWB Strategy in helping to work through these”,
“To have a 1 yr. annual report on HP or cross-cutting themes or to take one ambition”,
“City ownership not just looking to Public Health, or the Local Authority – there are city targets for obesity, tobacco/smoking – all of those things that are considered to be lifestyle choices”,
“Where the board could have influence and use their lever to lobby PHE or the press or government for change”,
“everyone should have access to a healthy diet, but they can’t because the money isn’t there, poverty is there, and these should be the focus for us all as organisations”.
One individual gave an example of an instance where working together was used and have great outcomes, “Tobacco and the work we have done, is a success story, we nearly compete with the Home Counties on Smoking prevalence, so in the refresh we ought to make a bigger effort on all of these lifestyle programmes”.

The following large quote gives a lot of insight into what is required of the HWB,
“WE have a very fragmented welfare system, system of support, benefits system, which people don’t know how to access that system until its too late and they are in crisis, or close to crisis. How do we encourage people on the front line to direct them, it’s about linking people together to those who are struggling, who are in crisis? People will remain well if they are financially well – there is more work to do to make that support more visible”.
In order for this to be achieved and successful it needs to come from a provider that reflects structure and interconnectivity.

Again, ideas of membership and responsibility were raised,
“I don’t account to the HWB Board or to the strategy. There’s no ask of Tobacco or the Tobacco strategy to report to the HWB Board. The only time Tobacco was asked to go to the Board was when the prevalence was dramatically reduced.”
“Move More and Physical Activity is a big part of the 9 ambitions. It’s such a significant role but no one ever asked me to summarise its impact. I attended the board 3 years ago and I would welcome the opportunity to sit on the board regularly to provide updates and to feel that I am accountable to the HWB Board and to the Strategy. I’d welcome those connections”.

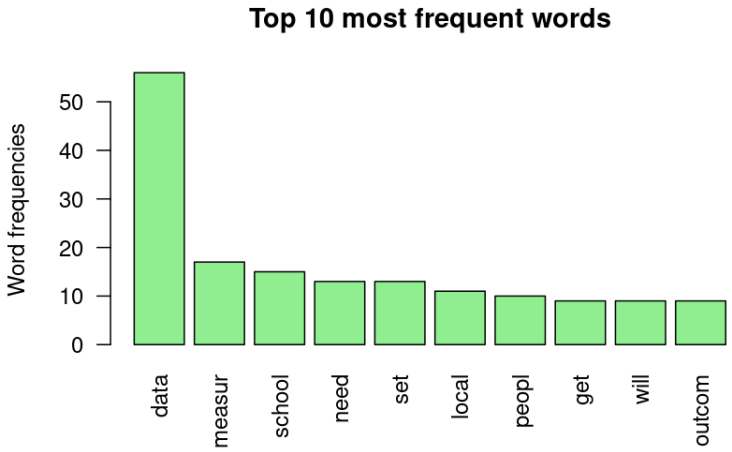
This last quote also links to the idea of resources not being used or available, the persons acknowledged their responsibility but does not feel that the opportunity for them to fulfil this responsibility has been available. Both of these quotes pain quite a fragmented picture of the membership and structure of the HWB.

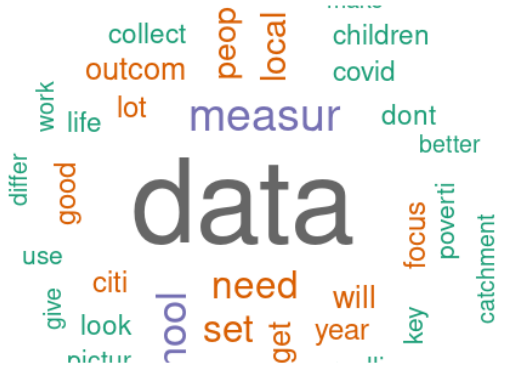
In terms of hopelessness, which has previously mentioned, there was evidence of it in some responses to this questions,

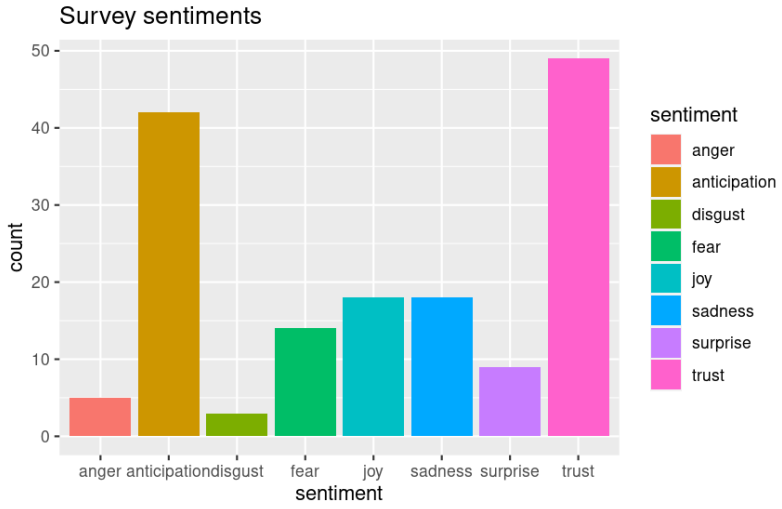
> “How does the city have a Mental Health Strategy as the NHS own it, so Mental Health becomes medicalised, and individualised? Oral Health is a bit homeless. Then there are nebulous and difficult things we don’t do properly or genuinely, homeless things which the board does need to think through”,

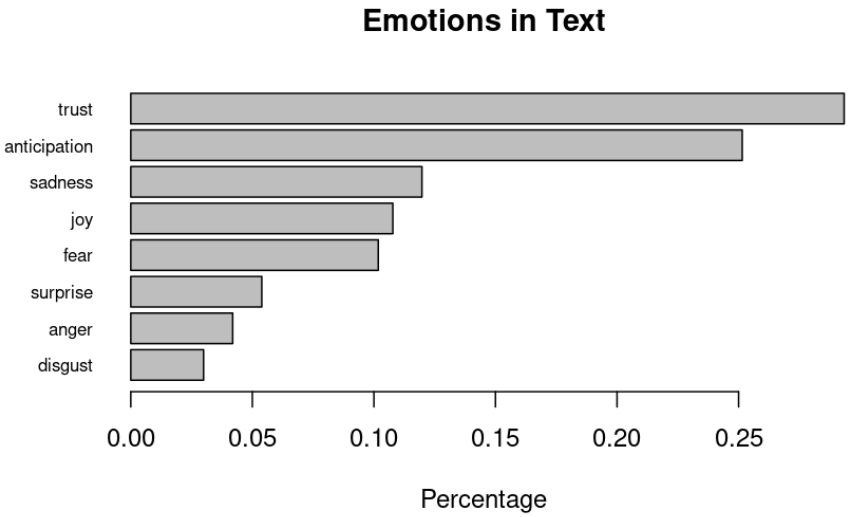
The individual in this case makes good, evidence based suggests for the future based on current weaknesses.

Q12 **Thinking about the Use of Data: What are the area specific or policy specific 'Good outcome metrics' on the service which would serve us best to use?**









Within this question there was a lot of discussion around data, resources their usefulness and limitations. With specific details on purpose and in depth, specific data on certain criteria,

"Child Poverty Data – the figures don't reflect single young people's poverty. The data sets available are not good it's hard to identify poverty",

"We don't have data from the food banks ",

"Use of Economic Data. Early Years and Economic Data – you can change. We need to lean on that data more, to bring the data as evidence the city more",

"We need to look at the absolute data of Yr. 1 of Covid",

"Collectively as a HWB Board and as a Local Authority we collect lots of data – if we agree what are the key measures that will make a difference",

"Activity and exploration – opportunity to dive into data and insight and developing action you get real energy and where you get the lever are – a strategy should be driving that focus",

"We measure our success by outputs and outcomes, and case studies – it's both quantities and qualitative. There are data sets, but they have never been defined by the board on what was needed, we were hoping for an Action Plan in May 2020 but Covid impacted on that",

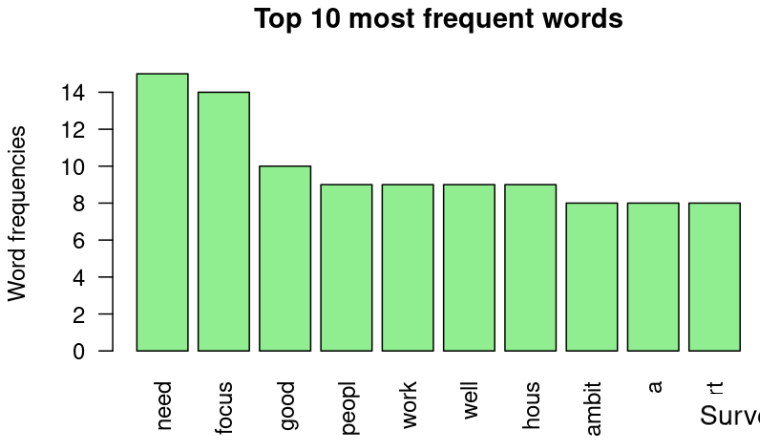
"What data sets are there, what have they been measuring and how effective have they been. What are the data sets against 3-year-olds and under for Starting Well to say we really made a difference again, or not?".

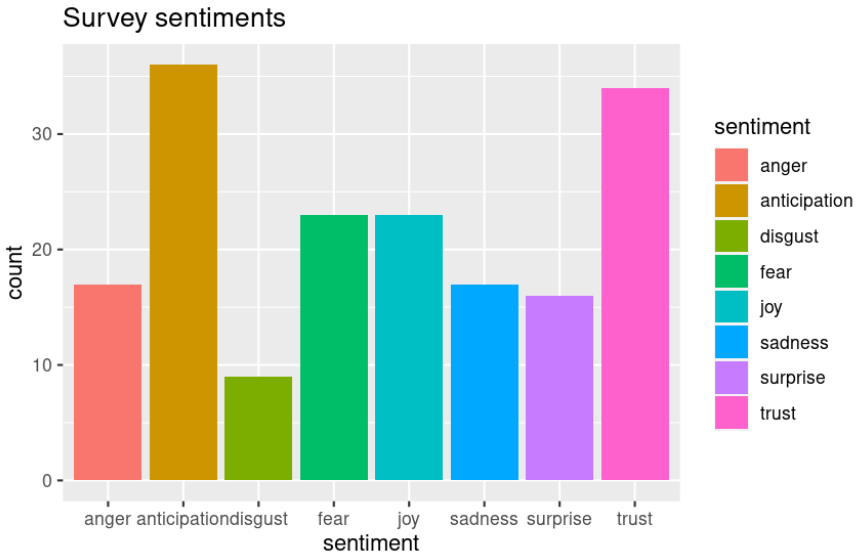
In line with running themes, one individual commented on the measurement of data and its relation to the 9 Ambitions. Looking at it from a wider perspective could this be linked to why some of the ambitions need refining, so there is the opportunity to measure the outcomes/contributions towards them?

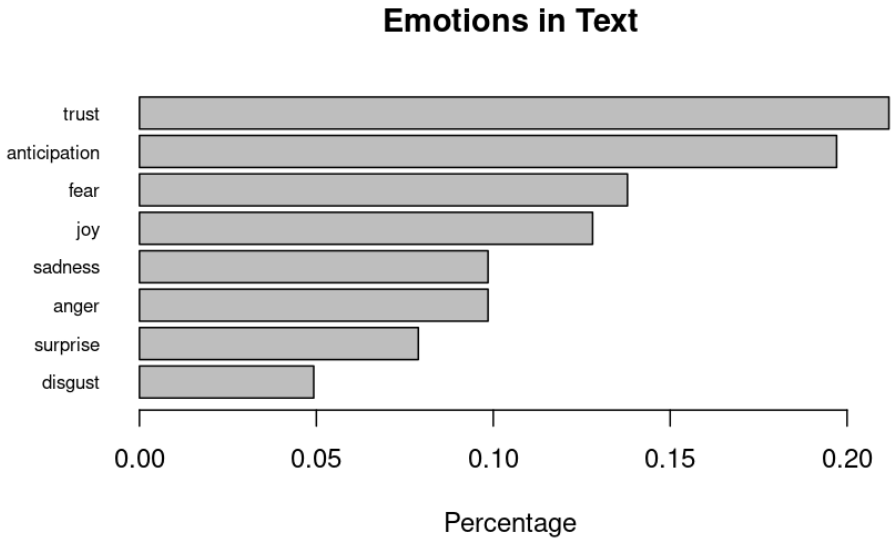
"I don't know what the key indicators are against the 9 ambitions. What's the data behind them? What outcome measurements – we don't get feedback on that and how we link what we do in Communities to the strategy – that feels vague and woolly".

It appears that the largest issues in reference to data is our ability to measure its usefulness and compare it to other, existing data. There are 3 key barriers to this, firstly if the data is not specific enough then it will not be accurate, reliable or generalisable. Second and third are both cross cutting themes which keep being raise, how can we measure success and thirdly communicating with one another to use data from different areas of expertise.

Q13 Critical Reflection: Thinking about our opportunities for making a difference/or real change? If you could choose now, what would be your top 3 opportunities for the Board to work on, which you think we could get right? Where we could move towards our overall goal of closing the gap of overall life expectancy?







The feedback for this question was very reflective of the text analysis, specifically the heightened data in sadness and anger (higher compared tot hat of the other questions), “You won’t achieve your real ambitions if you only focus on modifying your harm”.

Working together, community and interconnective was very prevalent throughout this data. Applying the data and resources is just as important, if not more, than the initial research – again stress on sharing this information and bringing people together,

“I have a cross-cutting role for Education, Learning, Health and the Children’s Hospital. There is an opportunity there for greater integration going forward, in the Children’s world particularly, in commissioning. The Strategy should have a need to go align to joint commissioning intentions across to the HWB Strategy ambitions/themes. We can’t health service our way out of the HWB Strategy outcomes”,

“Having the words isn’t enough. You have to operationalise it. To understand what and what we are doing – there will be a difficulty around resource but if we want to commit to it then we need to do further work to bring people along with us”,

“Probably should all collectively /the strategy should mean everyone has the same priority which they focus on – and to do 1 thing – we all agree as a Board of partners to use our resources in a way that achieves good health and wellbeing”.

In addition to membership and connectivity the structure of the HWB and its weaknesses was also talked about, “The structures don’t enable that, but its time maybe to really throw it up into the air and change how we do it”.

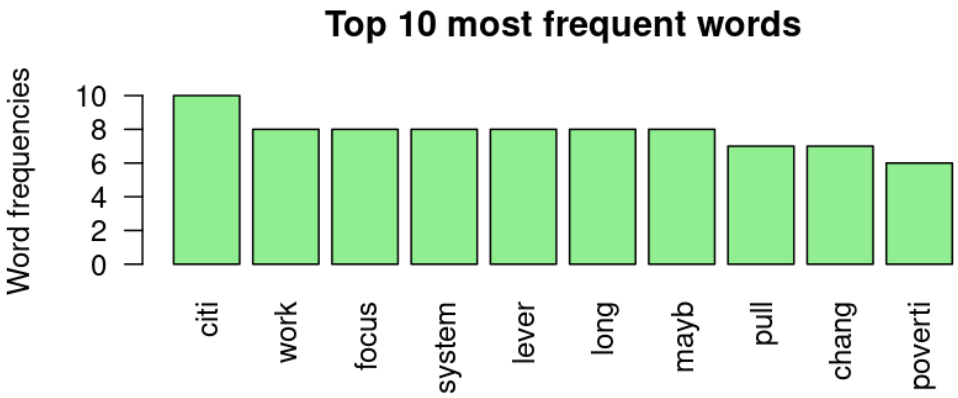
There was also the suggestion that the HWB has lost momentum and morale as a result of the high intensity covid responses – something that we have seen throughout this analysis,

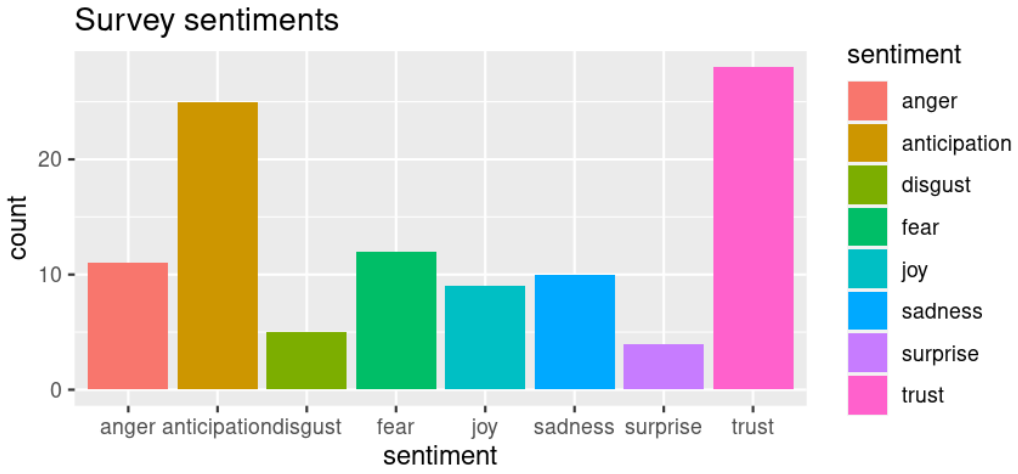
“It’s been a challenging time with the pandemic, everyone has been so stretched. Relationships have been lost or suffered not seeing one another face to face, and the chat over the cup of coffee after a meeting – has contributed to statis, but it feels like we are ready for a refresh”.

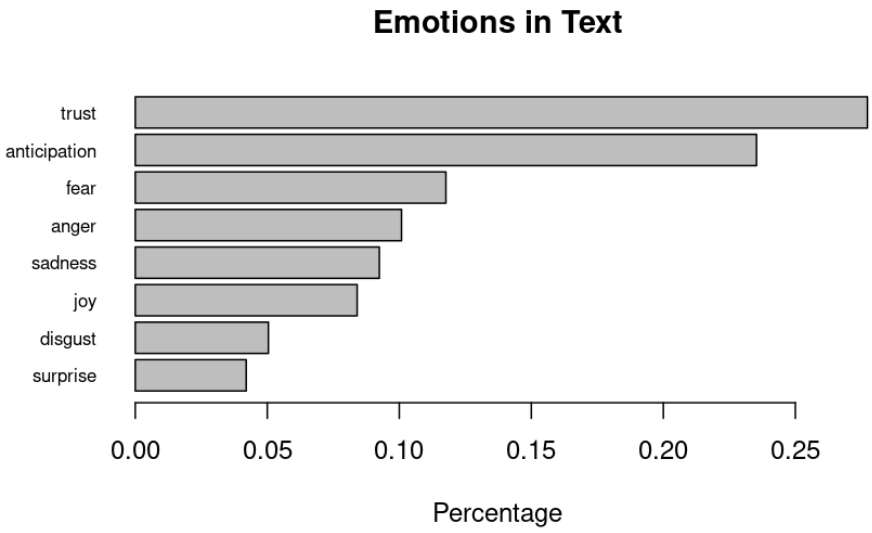
The following quote touches upon a lot of the overarching key themes present in this research,

“The key driver is supporting resilience and investing in social infrastructure and support and connectivity for people and particularly for Families and Young People . The impact of Covid and from the EY workshop which I was involved in the loss of young children’s’ social skills and motor skills . Wanting to work upstream – it’s a big gap to close – but resilience and investment in communities is key”

Q14 **In your opinion what are the key leverage points/the big macro leverage points that would shift the whole system?**







Most of the response to question highlighted weakness in the current structure, membership and collaboration of the HWB,
"the HWB Board is a crucial place to pull up and to look at the collective city levers we could use to work on poverty and a long-term view/action plan for reducing poverty and inequality in the city. It's the whole city's responsibility",
"how do we bring that same focus to this work the cognitive diversity",
"Recognising collaboration and connection can result in a bigger lever – we can have more impact.
Its about connecting up – working as a system – recognising the smaller interdependencies and inter relationships and connecting up ",

"There's a timidity about the board – it has a lack of teeth, and a model which presumes a level of influence".

These comments highlight the responsibility that the board holds to work as one as it benefits the city and communities as they can work more effectively and efficiently.

Another themes that was talked about was the focus of the board,

"to look at the collective levers we could pull up as a city – the HWB Board is a crucial place to pull up and to look at the collective city levers we could use to work on poverty and a long-term view/action plan for reducing poverty and inequality in the city",

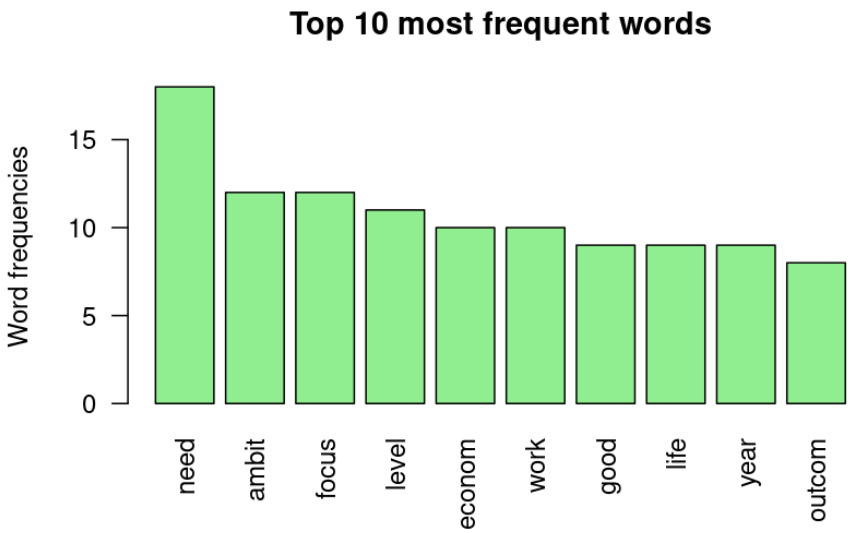
"Let's face it there is more money in health (the NHS) than in the Local Authorities, but its joint business and to be able to influence Health money being spent on things like Housing, boilers, insulation – it will pay for itself in the long run",

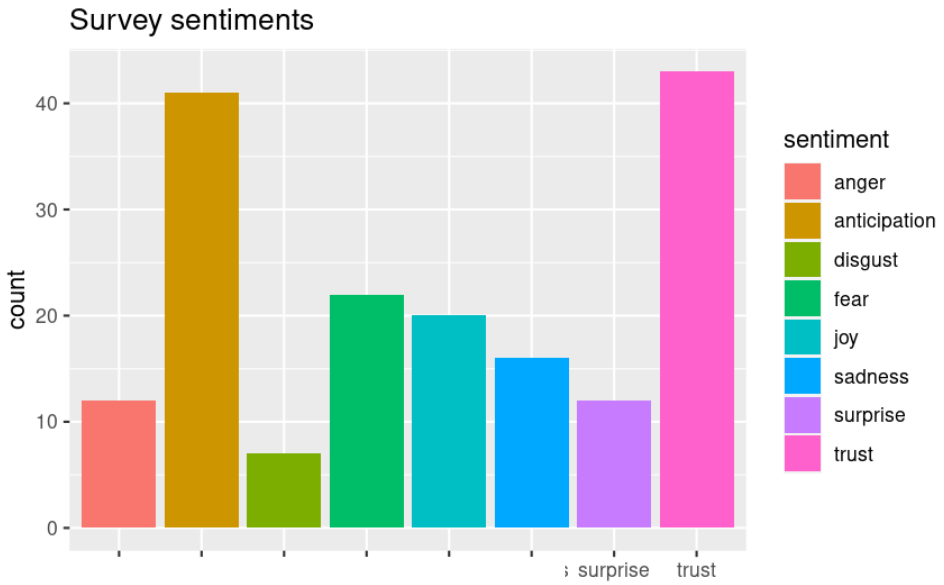
"then maybe we take 1 priority and we focus on this".

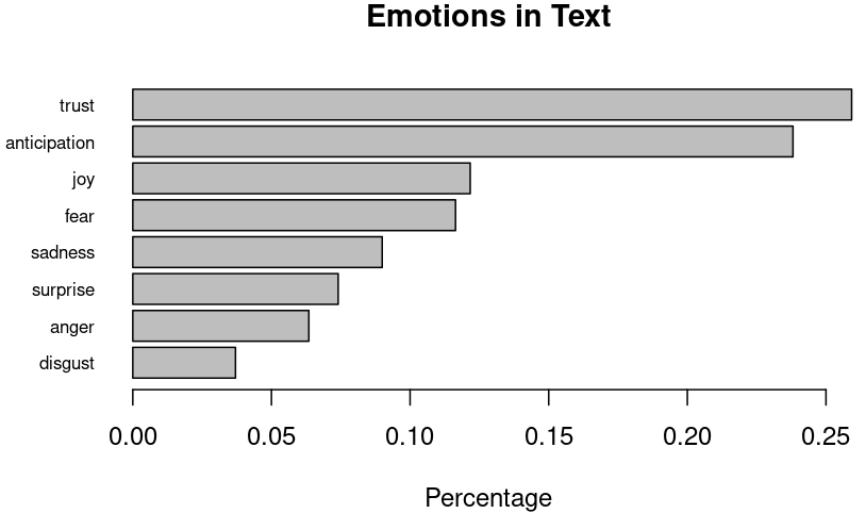
What these comments highlights is that by refining what the aims are and focusing on one thing so the process and outcome can I be more effective. This will also promote productivity and interconnectivity simultaneously.

Lastly the following quote links to anticipation and wanting to move forward and make developments. This suggests that the momentum of the HWB and members is not all lost or diminishes as some of the data from the Covid theme would suggest,
"Maybe we have to tip the scales, maybe we don't do enough of tipping the scales, - maybe its going to take a radical approach and a long vision. **Born in Bradford t**hey did this, they focused on Early Years, I don't think we ever did this in Sheffield. But it could be something we would be known by".

Q 16 **What Next? Where should we put our effort/energies, resources**?







Whilst the following question did not necessarily draw out any themes, in response to the question itself people made a variety of suggests for the future of the HWB and its focus,

“Mental Health an All Age Mental Health focus. MH is recognised in the NHS Long Term Plan especially with Covid it has exacerbated it., so much that we can t meet the level of demand that s coming through the door”,

“Its about having a common purpose and common approach if we think about the life expectancy and narrowing that gap. Seen as a core activity and everyone works and agrees to do it. It should be the right thing to do for every organisation as core group for HWB and not necessarily the best thing to do for their organisation”,

“The health & wellbeing of young mums the role of parents and parental influence all of these ”, “things we see as GP s realistically, we have to be doing work in those parts of town”,

“To have lots more work in Early Years Life course (Starting Well Ambitions 1,2,3) and a culture of Prevention would impact on health economics and the savings in the long term”,

“Mid life interventions there is a dearth around this and Physical Activity, its not just about the menopause, its wider than than, and it’s an important intervention point for growing healthcare”,

“Integrated Care Partnership and How is health money going to flow into Sheffield and the role of the HWB Board in influencing how it s being spent in Sheffield as a city”,

“Need to have a way forward and not necessarily to do everything, and to reflect on do you look at the big issues like the big killers? What value would the HWB Strategy add? What are the levers which individual partner organisations have to do around poverty? ”,

“The Health & Wellbeing Strategy with the Health & Wellbeing Board for delivery or success it someone has to drive it, or to be driving it it needs resourcing. It needs to have a dedicated resource and capacity would also be a good place to start”,

“Needs to be a national/regional/ and local response we cant solve this on our own as a Local Authority”,

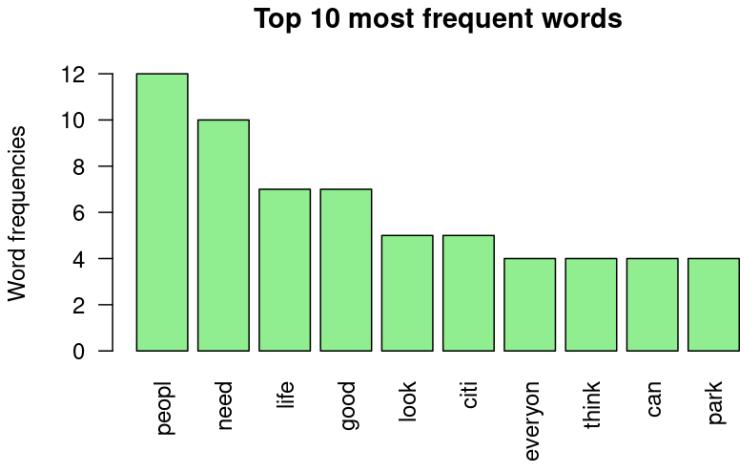
“Covid has had a massive impact and it will have affected our population we need to focus on a redress. We have to address some of the fundamental issues in society people living their worse lives rather than their best life and to be able to access what they need to live a good life”,

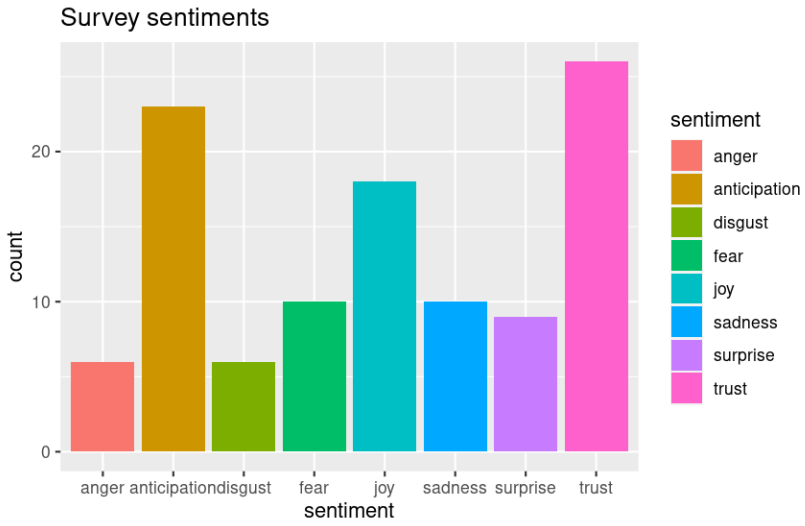
“I see 2 priority areas in Living Well and Starting Well and these ambitions/priority areas”,

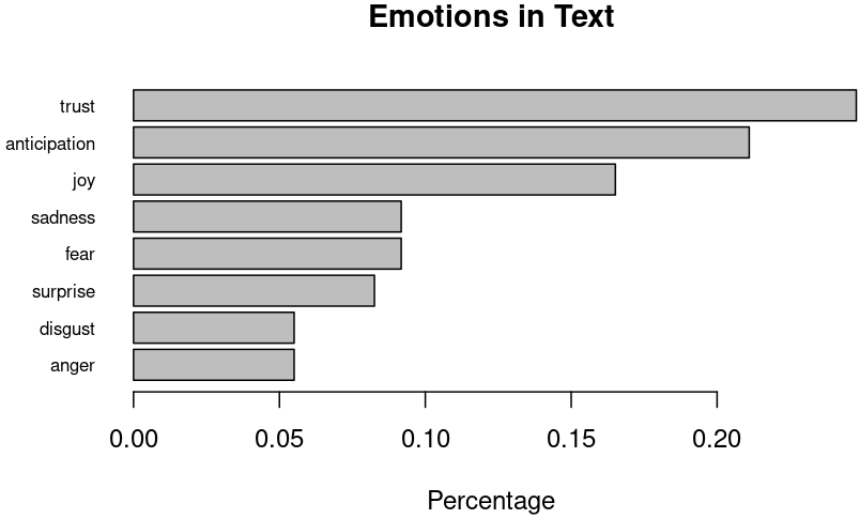
“Two critical things which I feel the Strategy should focus on: Mental Health it s always an issue in the data, I am not sure that it comes out strong enough in the 9 Ambitions, in that Life Course Methodology”.

However, once again measurement was brought into question, as was the effects Covid has had on the city and the HWB.

Q17. **The Bigger Picture: How does "Health" fit into the city strategy overall?**







The question brought up a lot of very important points. The two following quotes present well rounded and key changes they wish to see in the HWB,

"The Health & Wellbeing Board needs to be a better meeting, better organised and understand its powers better. Also there's an opportunity for a place based Health &Wellbeing Board, and to the new Integrated Care System as a financially weight bearing organisation. It's not enough to go 'this is our strategy' the Health & Wellbeing Board needs to be a pressure organisation – it needs to be lobbying for these who can deliver, it needs to be more active in influencing that underneath it",

"To deliver the strategy, To be involved in cultural change in those organisations. Some if it is a matter of will and a matter of focus .The consequences of facility to do the HWB Strategy/board stuff. The Board needs to be making demands to those who hold the purse strings. It should be reversed – HWB Board should be the influence, and the strategy should set out its stall".

Points regarding focus were also brought up,

"Currently the ambition to reduce inequality around life expectancy and healthy life expectance is to reduce a negative. What if we turned that on its head, and went instead for a positive approach like this? It would have the outcomes around the ambitions but in a non-negative focus way**",**

"The Economic data as the driver",

"Health is a personal journey and relating to it in that way, as a sector we value have to be data led, and value insights and the life story and the life cycle".

In addition, connectivity, collaboration and working together was once again brought up,

"If we only look from a health perspective and not Health & Wellbeing – how can we ensure that our population with needs have their health needs met",

"Its about connecting and inclusive growth for the people in communities",

"Everyone wants to own health – medicalisation and individualisation of health and the bugbear is the narrative that brings it all together".

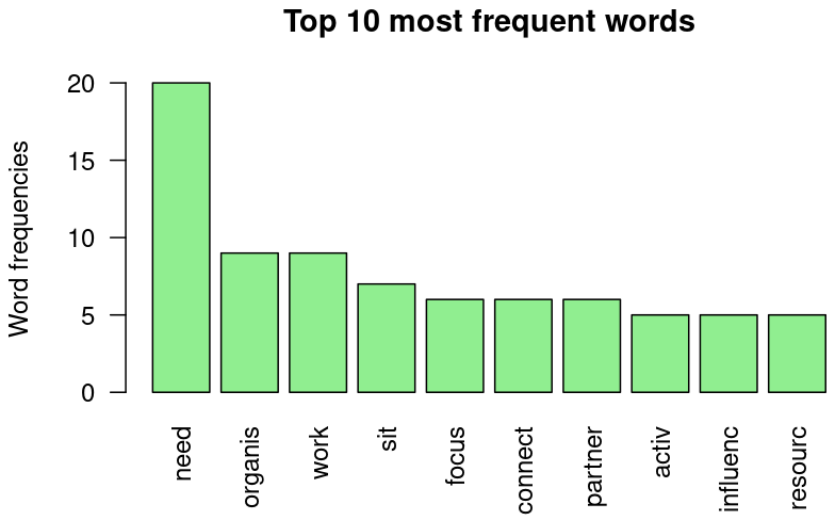
Lastly, the following quote brings up a point that has been touched on previously,

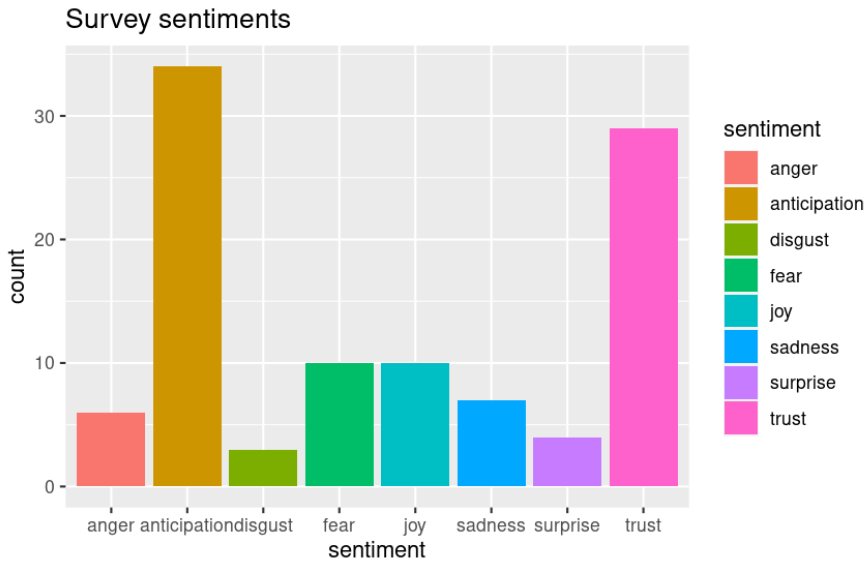
"What do we mean – to go back to the WHO definition of Health (insert quote) People equate health with healthcare. People's feelings on health and what it means to them is very contextual. But for Health to ask, what are those foundational building blocks which enable us to grow health, and to look at those building blocks – what things enable us to grow in life?",

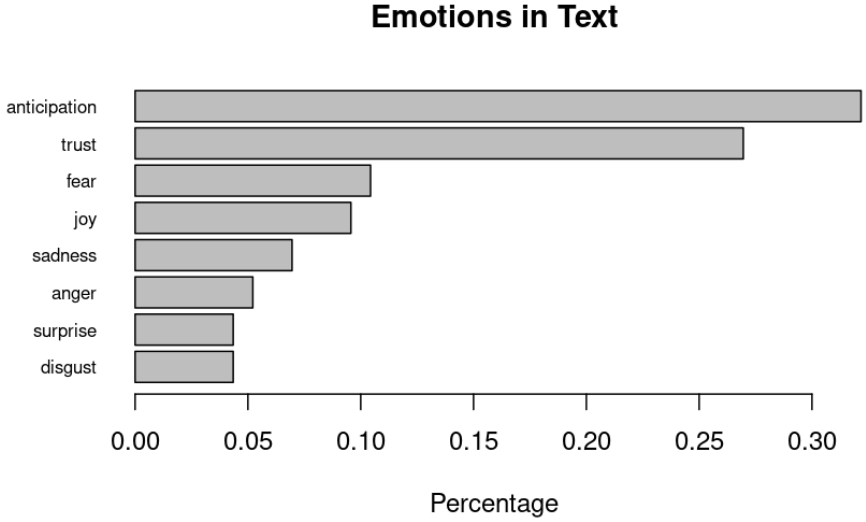
It might be the big question within PH, however it is a good argument for the HWB to use to rebuild, what is health to you. It is all subjective, 100%, obviously creating services and promoting health which applies to all is highly unlikely. However, can we re-adjust the focus of the HWB to compliment this more? This person goes on the stress a point that has previously been mentioned, that the board needs to reflect what is the social and political focus/crisis at the moment. Does the HWB need to be more fluid?

Similarly, the idea that "we tend to look at Health through the physical conditions, through disease, its much more than that" has come up before. Does this need more attention due to Covid and the social changes it has affected.

Q17c What the Board can and cant do per say?







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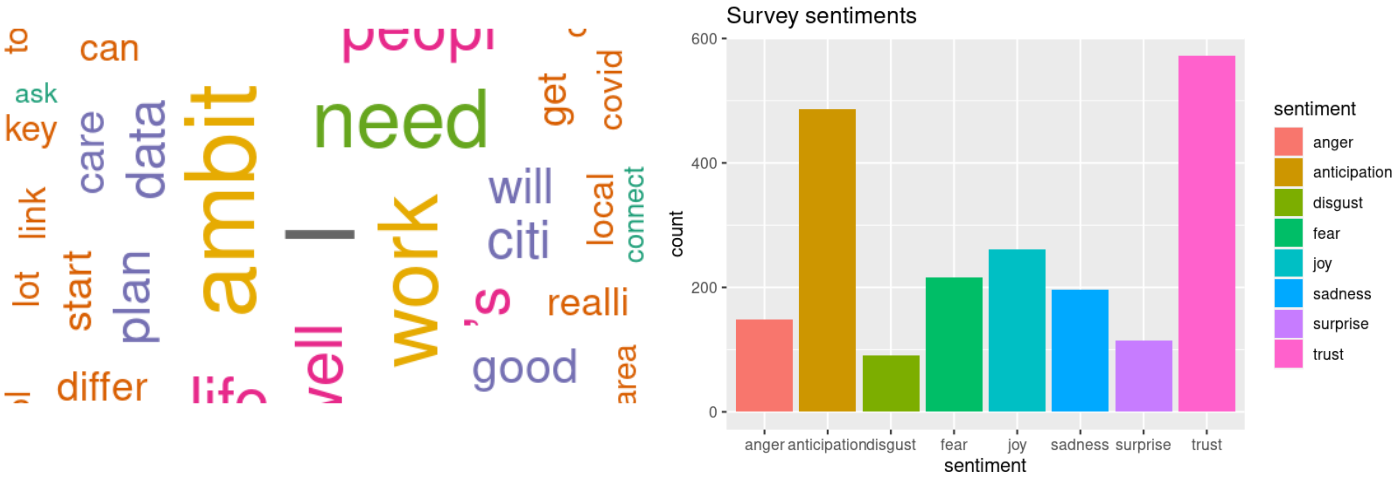

Words used in sentiment and association:

Table of words associated with the sentiment words:

Word	Anger	Word	Fear	Word	Joy	Word	Sadness
outraged	0.964	*horror*	0.923	*sohappy*	0.868	*sad*	0.844
brutality	0.959	*horrified*	0.922	*superb*	0.864	*suffering*	0.844
satanic	0.828	*hellish*	0.828	*cheered*	0.773	*guilt*	0.750
hate	0.828	*grenade*	0.828	*positivity*	0.773	*incest*	0.750
violence	0.742	*strangle*	0.750	*merrychristmas*	0.712	*accursed*	0.697
molestation	0.742	*tragedies*	0.750	*bestfeeling*	0.712	*widow*	0.697
volatility	0.687	*anguish*	0.703	*complement*	0.647	*infertility*	0.641
eradication	0.685	*grisly*	0.703	*affection*	0.647	*drown*	0.641
cheat	0.630	*cutthroat*	0.664	*exalted*	0.591	*crumbling*	0.594
agitated	0.630	*pandemic*	0.664	*woot*	0.588	*deportation*	0.594
defiant	0.578	*smuggler*	0.625	*money*	0.531	*isolated*	0.547
coup	0.578	*pestilence*	0.625	*rainbow*	0.531	*unkind*	0.547
overbearing	0.547	*convict*	0.594	*health*	0.493	*chronic*	0.500
deceive	0.547	*rot*	0.594	*liberty*	0.486	*injurious*	0.500
unleash	0.515	*turbulence*	0.562	*present*	0.441	*memorials*	0.453
bile	0.515	*grave*	0.562	*tender*	0.441	*surrender*	0.453
suspicious	0.484	*failing*	0.531	*warms*	0.391	*beggar*	0.422
oust	0.484	*stressed*	0.531	*gesture*	0.387	*difficulties*	0.421
ultimatum	0.439	*disgusting*	0.484	*healing*	0.328	*perpetrator*	0.359
deleterious	0.438	*hallucination*	0.484	*tribulation*	0.328	*hindering*	0.359

Table 2: Example entries for four emotions in the NRC Affect Intensity Lexicon. For each emotion, the table shows every 100th and 101st entry, when ordered by decreasing emotion intensity.

Conclusions:

- Highlights a generally positive response – this requires further investigation for context?
- Whilst there is more positive word associations than negative
- Confidence refers to the assurance that we have on someone. Trust, on the other hand, refers to the firm belief that one has on another individual. When considering both words, it is often hard to differentiate one from the other. This is because these words are very much linked to one another.

Appendix 3.

Interview questions

Section 1: Context Setting

1. Given that we have been dealing with the Covid-Sars pandemic for the past two years, how familiar are you with Sheffield's current Health & Wellbeing Strategy? (see qualifiers in Q2 VW, W, NsW, NaA)

2. How much has it been a key part of your responsibility/role to take it forward (and/or to take Priority X forward)?

a Very well

b Well

c Not so Well

d Not at All

Have you been able to contribute to the HWB Strategy and on the delivery of the strategy? (As above/ VW, W, NsW, NaA)

Have you had an opportunity to report back/contributed to the HWB Board to update on progress made on your priority?

Our Goal
Healthy life expectancy is the best overall measure of both health and health inequalities, representing as it does the number of years someone can expect to live in good health. In Sheffield, the gap between the best and worst off is around 20 years. Our goal is therefore:
We will close the gap in healthy life expectancy in Sheffield by improving the health and wellbeing of the poorest and most vulnerable the fastest
Have we realised our goal? Y/N/ If not, why not? What could we improve? What can we learn from?

a. **Very Well**

b. **Well**

c. **Not so Well**

d. **Not at All**

Looking at The 9 Ambitions (see Ambitions Page)

How well have we delivered on our 9 ambitions? How well has your ambition been delivered on?

a. **Very Well**

b. **Well**

c. **Not so Well**

d. **Not at All**

What is already in the strategy (the 9 ambitions) and what is happening in each of the areas current state of play and main recent developments? In any of these ambition areas there is a whole range of activity. Much of it is just part of routine business of one of more of the organisations or constituencies who make up that area.

What <u>strategies</u> already exist and are being implemented within the scope of each of the 9 ambitions? *To get from the interviews a sense of what strategies already exist and are being implemented within the scope of each of those ambitions*

For example, within the ambitions:

• Ambition 1 – what is in the box around the First 1001 days, the Infant Mortality Strategy, school readiness

• Ambition 4 on housing there will be on homelessness private rented sector, affordable housing, hazards in homes, fuel poverty, building the right number of homes.

• Ambition 9 – End of Life there are three main strands – compassionate

• communities, clinical pathways, business intelligence. Each of which has sub themes.

• Are you aware of the **Covid Inequalities Review /**have you had a chance to see the report completed by Beth Williams? How could it align with the HWB Strategy and other city strategies

What is the broad ask of the city in terms of **partnership working to improve the trajectory of key outcomes?** What can you or your organisation do to improve this cross-sector collaborative trajectory?

Thinking about the **big areas that are not explicitly named/checked within the HWBS but contribute significantly to health** – e.g. Smoking, Food, Activity, Health Protection, Poverty, Economic strategy, ***where is their place in the HWB Strategy Review?***

Interviewee Notes) Many stakeholders outside of each of those three areas will not know of the complex world within it so use the interviews to bring some of that out

Thinking about the Use of Data: What are the area specific or policy specific 'Good outcome metrics' on the service which would serve us best to use? *Interviewee Refer to new data source Local Insight (communityinsight.org)*

Critical Reflection: Thinking about our o**pportunities for making a difference/or real change**? **If you could choose now, what would be your top 3 opportunities** for the Board to work on, which you think we could get right? Where we could move towards our overall goal of closing the gap of overall life expectancy?

In your opinion **what are the key leverage points/the big macro leverage points that would shift the whole system**?

Where are we in a position to **change trajectory**? Where aren't we in a position to change trajectory? (this enables a bit of insight into state of play in each of the spaces)

What Next? Where should we put our effort/energies, resources?
Interview Note: critical areas that are not referenced / explicitly name checked in HWBS

The Bigger Picture: How does "Health" fit into the city strategy overall?

What areas overlay or overlap?

What CAN and CAN'T the BOARD per se do

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HEALTH AND WELLBEING BOARD PAPER

FORMAL PUBLIC MEETING

Report of:	Emma Latimer: Executive Place Director for Sheffield, NHS South Yorkshire ICB Greg Fell: Director of Public Health, Sheffield City Council
Date:	29th September 2022
Subject:	South Yorkshire Integrated Care Partnership
Author of Report:	Sandie Buchan: Director of Commissioning Development for Sheffield, NHS South Yorkshire ICB Will Cleary-Gray: Executive Director of Strategy & Partnerships, NHS South Yorkshire ICB

Summary:

The South Yorkshire Integrated Care Partnership (ICP) has been established as per the requirements of the Health & Care Bill 2022. The Bill requires Integrated Care Boards and Local Authorities to come together, as equal partners, in a joint committee to facilitate joint action to improve health and care outcomes and experiences across the South Yorkshire population.

The ICPs' central role is in the planning and improvement of health and care and will bring the statutory and non-statutory interests of places together.

The ICP will develop an integrated care strategy that will align with the individual place Health and Wellbeing strategies across South Yorkshire, which will address the broad health and social care needs of the population, including determinants of health such as employment, environment, and housing issues.

ICBs and Local Authorities are required by law to have regard to the ICP's strategy they develop when making decisions, commissioning health and care services and delivering services.

The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to take action where required. These include, but are not limited to:

- Helping people live more independent, healthier lives for longer
- Taking a holistic view of people's interactions with services across the system and the different pathways within it
- Addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- Improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
- Improving the life chances and health outcomes of babies, children and young people
- Improving people's overall wellbeing and preventing ill-health

The South Yorkshire ICP will enable partners to plan for the future and develop integrated strategies for using available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector of organisation alone. The ICP will complement the established place-based working and partnerships we already have in Sheffield by developing relationships and tackling issues that are better addressed on a bigger area.

Sheffield health and care system will take on a central role in population health management, planning and improvement of health and care, joined up service provision, and building broader coalitions to promote health and wellbeing. We will also ensure that our communities voices are at the heart of the decisions that we make as a system and feed them into the discussions within the ICP.

The attached paper was developed by the original members of the ICB, including Local Authority Chief Executives and the Health and Wellbeing Board Chairs across South Yorkshire, and the proposals were presented in May 2022. It was agreed by the original ICP members for each H&WBB to nominate five members to sit on the ICP.

The ICP nominated members from Sheffield are currently:

- Councillor Angela Argenzio, Chair of Sheffield Health & Wellbeing Board
- Greg Fell, Director of Public Health
- Alexis Chappell, Director of Adult Health & Social Care

With two nominations outstanding.

The South Yorkshire ICP will meet for the first time on 23rd September 2022 and will be chaired by Mayor Oliver Coppard, MCA.

Questions for the Health and Wellbeing Board:

- **Propose another two nominations to be put forward for South Yorkshire ICP membership.**
- **Does the Board approve the existing three nominations for South Yorkshire ICP membership?**

Background Papers:

- *Proposals for an initial South Yorkshire Health & Care Partnership Forum (ICP)*

Author: Will Cleary-Gray, Executive Director of Strategy & Partnerships. 17th May 2022.

Which of the ambitions in the Health & Wellbeing Strategy does this help to deliver?

All.

Who has contributed to this paper?

Sandie Buchan: Director of Commissioning Development for Sheffield, NHS South Yorkshire ICB

Will Cleary-Gray: Executive Director of Strategy & Partnerships, NHS South Yorkshire ICB

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Title	**Proposals for an initial South Yorkshire Health and Care Partnership Forum (ICP)**
Author	Will Cleary-Gray, Executive Director of Strategy and Partnerships (designate)
Audience	Initial consideration by Health and Wellbeing Board Leads and Lead Officers South Yorkshire and Bassetlaw Partner Organisations
Date	17 May 2022

Summary

- South Yorkshire Partners have been working together to implement the Health and Care Bill, published on 6 July 2021 which became an Act of Parliament on 28 April 2022.
- As a result of the Act, Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) are to be established.
- South Yorkshire has well developed relationships and arrangements between health, local authorities, the voluntary sector and wider partners in each of our four Places.
- ICP will evolve as more is understood about how they will work and in context of the Government's recent Integrating Care White Paper.
- Integrated Care Boards and Local Authorities are responsible for establishing ICPs as equal partners.
- Guidance on ICPs has been published providing a framework for development and setting out their key role and purpose.
- Initial proposals for a South Yorkshire interim ICP were put forward in 2021. These have recently been refreshed and reshaped further by Health and Wellbeing Board elected members and lead officers.
- The Act requires all systems are to have at least an interim ICP up and running when statutory ICBs commence on July 1st 2022.
- An interim ICP comprise a chair and a committee of at least statutory members (the ICB and local authorities), and for there to be agreement on how the committee will be initially resourced.
- Proposals for a refreshed initial ICP is set out in this paper including a first meeting in shadow form in advance of July 1st.

Key questions?

- **Do the proposals feel about right for an initial ICP for South Yorkshire?**
- **Do the proposals respond to the challenge of inclusivity and effectiveness?**
- **Has the proposal captured the key purpose and role of the ICP?**
- **Is the proposal for an elected councillor to chair the ICP supported and how might we take that forward?**
- **Do the key immediate next steps cover what we need to do next (page 6)?**

Purpose

1. This purpose of this paper is to summarise progress and set out proposals to implement the Health and Care Act, 2022, with respect to Integrated Care Systems and the establishment of a South Yorkshire Integrated Care Partnership forum (ICP)

2. These build on the progress made by the South Yorkshire and Bassetlaw Health and Care Partnership which includes the proposals **it consulted partner organisations on** in 2021. It also includes recent engagement with all four Health and Wellbeing Board elected members and lead officers in Barnsley, Rotherham, Doncaster and Sheffield, to shape and inform refreshed proposals for an initial South Yorkshire ICP, in readiness for July 1st, 2022.

3. Important to note - these initial proposals reflect two key factors:

    - we have well established relationships and arrangements between health, local authorities, the voluntary sector and wider partners in each of our four Places across South Yorkshire and these themselves are local health and care systems critical to delivering our quadruple aim for local populations

    - any arrangements for a South Yorkshire ICP will evolve as we understand more about how this will work in context of wider current arrangements, the Government's recent **Integrating Care White Paper -Joining up Care for People, Places and Populations** and what is best for South Yorkshire citizens, patients and its four Places

Background

4. In November 2020, South Yorkshire and Bassetlaw Health and Care Partners agreed a set of arrangements to respond to the WhitePaper ***"Integration and Innovation: Working together to improve integration and innovation for all"*** and subsequent Bill published in July 2021. This included the establishment of an ICS Development Steering group involving all partners across the ICS including Local Authorities, VCSE, Providers, including Primary Care, Mental Health and Children's Services, Commissioners and reflected the key building blocks of our ICS including at that time all five Places (including Bassetlaw) , Partnerships and Collaboratives and Alliances.

5. The steering group considered national guidance and engagement documents including published guidance on **Integrated Care Partnerships (ICPs)** and put forward proposals for a **Health and Care Compact (Annex, A)** which enshrined the commitment of South Yorkshire Partners to deliver the quadruple aim to address inequalities – this now underpins the Constitution which governs the South Yorkshire Integrated Care Board.

6. The steering group also put forward proposals for a refreshed Health and Care Partnership to serve as initial arrangements for a South Yorkshire ICP – these proposals build on these.

7. The Health and Care Bill became an ***Act* of Parliament on 28th April 2022** by royal assent and South Yorkshire partners are working together to make final preparations to established key components which include Integrated Care Partnerships (the focus of this paper), Integrated Care Boards, local Place-based arrangements, Provider Collaboratives and Alliances, ready for July 1st.

Integrated Care Partnerships published guidance - summary

8. The **engagement document on ICPs** jointly developed by the Department of Health and Social Care, NHS England and NHS Improvement and the Local Government Association (LGA), give consideration of how the Bill (now and *Act*), applies to ICPs – in summary and from this guidance:

9. Statutory Integrated Care Systems have two key components:

    i. a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.

ii. a statutory body, the integrated care board, or ICB: the ICB will be responsible for the commissioning of healthcare services in that ICS area, bringing the NHS together locally to improve population health and care.

10. The ICP provides a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from across the system and community.
11. They have a critical role to play in ICSs, facilitating joint action to improve health and care outcomes and experiences across their populations, and influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies.
12. They will consider what arrangements work best in their local area by creating a dedicated forum to enhance relationships between the leaders across the health and care system. For example, the NHS, local government, public health, adult social care, employment support, and VCSE coming together to build a culture of partnership and broad collaborations to promote and support holistic care.
13. ICPs' central role is in the planning and improvement of health and care. They should support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas. ICP should bring the statutory and non-statutory interests of places together.
14. ICPs are to develop an integrated care strategy to address the broad health and social care needs of the population within the ICP's area, including determinants of health such as employment, environment, and housing issues.
15. It is the responsibility of ICBs and Local Authorities to establish ICP arrangements and all systems are expected to have initial arrangements ready for July 1st, 2022.
16. ICBs and local authorities will be required by law to have regard to the ICP's strategy they develop when making decisions, commissioning health and care services and delivering services.
17. The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to take the action required. These include, but are not limited to:
    - helping people live more independent, healthier lives for longer
    - taking a holistic view of people's interactions with services across the system and the different pathways within it
    - addressing inequalities in health and wellbeing outcomes, experiences and access to health services
    - improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
    - improving the life chances and health outcomes of babies, children and young people
    - improving people's overall wellbeing and preventing ill-health
18. ICPs will enable partners to plan for the future and develop strategies for using available resources creatively in order to address the longer-term challenges which cannot be addressed by a single sector or organisation alone.
19. ICPs should complement place-based working and partnerships, developing relationships and tackling issues that are better addressed on a bigger area.
20. Places continue to play a central role in population health management, planning and improvement of health and care, joined up service provision, and building broader coalitions to promote health and wellbeing.
21. The principle of subsidiarity should be a driving force to ensure that decisions are taken by communities at the most appropriate geography.

Engagement with Health and Wellbeing Boards

22. In quarter 1, 2022 the newly appointed ICB Chair and Chief Executive (designates) met with Local Authority Chief Executives. This was to discuss next steps to take forward the work started and consulted on in 2021, to develop an initial forum for South Yorkshire ICP arrangements.

23. A key next step was to engage with each Health and Wellbeing Board elected member and lead officers in Barnsley, Doncaster, Rotherham and Sheffield Place to:

    - Reiterate the important role and synergies between Health and Wellbeing Boards and their statutory role and the Integrated Care Partnership and discuss how they could work well together.
    - Reflect on the published guidance above and gain input and views
    - Reflect on the work done by the ICS development steering group in 2021.
    - Test some initial thinking together on potential approaches and key considerations for the South Yorkshire ICP including: its core purpose and role, chairing, membership, meeting arrangements and establishing initial arrangements ahead of July 1st as expected following the Health and Care Act, 2022.

24. A meeting between each of the Health and Wellbeing board elected members and lead officers, ICS chair, chief executive (designates) took place over March and April and a summary of the discussions can be found in **Appendix, A.** In addition, a collective discussion was taken to the regular meeting of Health and Wellbeing Board Chairs and Leads, Lead officers and ICS / ICB leadership on 20th April 2022 to reflect back each of the individual discussions.

    In summary:

    - There was appreciation and support for the work which had been done to date including the Health and Care Compact and initial work on the refreshed Health and Care Partnership.
    - There was broad consensus on the purpose and role of the ICP for South Yorkshire noting its core role of development the system integrated care strategy and complementing place-based arrangements.
    - There was consensus for the importance of balancing inclusivity with having an ICP which was of a size that it could function effectively whilst meeting having a broad membership to be able to facilitate joint action on health and care and wider issues.
    - There was broad consensus of the importance of having an initial forum meeting ahead of the implementation date of 1st July.
    - Who would chair the ICP required further consideration and the ICB chair expressed a preference for this to be an elected member.

Proposals for and initial South Yorkshire ICP forum

25. A proposed way forward to establish initial arrangements for South Yorkshire are summarised in **Appendix, B.** These build on the guidance, the work to date and the input of Health and Wellbeing Board elected members and lead officers.

26. It is recognised that these arrangements will evolve as we understand more about how this will work in context of wider current arrangements and potential further changes as a result of the recent White Paper. They offer a pragmatic way forward to have an initial ICP ahead of July 1st.

27. In summary the proposal includes

Key purpose and role

Which is to:

- enhance relationships between the leaders across South Yorkshire health and care system.
- complement place-based working and partnerships, developing relationships and tackling issues that are better addressed on a bigger area.
- facilitating joint action to improve health and care outcomes and experiences across their populations, and influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies
- developing an integrated care strategy to address the broad health and social care needs of the population within the ICP's area, including determinants of health such as employment, environment, and housing.
- enable partners to plan for the future and develop strategies for using available resources creatively in order to address longer-term challenges which cannot be addressed by a single sector or organisation alone

Forum and membership

Proposal for initial arrangements:

- An ICP with a wide membership inclusive of the full range of statutory and non-statutory partners across the ICS and potentially wider **(see Appendix, C).** This could be in the region of 40 members including the ICB and Local authorities in each of the four places within the ICB geography.
- The ICP would be supported by a delivery group whose membership is drawn from our four Local Authorities and NHS. Up to eight from Local Authorities to include as a minimum each Local Authority Chief Executive and a nominated executive lead to support the work of the ICP. It could also include addition Local Authority members for example from directors of public health, directors of adult social services and directors of children's services. From the NHS up to eight members with a minimum of the ICB chair and chief executive and an executive lead from the ICB to support the work of the ICP. It could also include for example members from NHS Trusts, mental health and physical health, primary care, community and the voluntary sector. The ICP may choose to also convene larger assembly type forums to achieve greater engagement and involvement in its work.

Chairing

- The proposal is for one of the local authority elected councillors from within the SY geography to chair the ICP.
- Given the ICP is to be jointly convened by the ICB and LA. The chair will be jointly agreed.

Initial support and secretariat

- The ICB will provide initial interim secretariat support to the ICP for the remainder of 2022/23.
- The ICB will also identify a lead executive to work with the ICP on behalf of the ICP and undertake a review to identify existing resources which align to the work of the ICP.

The role of Health and Wellbeing Boards

28. Health and Wellbeing Boards remain as a result of the changes and have a critical part to play in the success of integrated working. They are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health

and local government. They have a statutory duty, with current clinical commissioning groups (CCGs), to produce a Joint Strategic Needs Assessment (JSNA)and a joint health and wellbeing strategy for their local population. In the future the executive place director of the ICB will be a key link working with HWBBs to support the above.

29. In most cases, Health and Wellbeing Boards are chaired by a senior local authority elected member. The board must include a representative of each relevant CCG and local Healthwatch, as well as local authority representatives. The local authority has discretion in appointing additional board members.

30. Health and Wellbeing Boards have a key role in supporting the underpinning development of the System Plan the ICP will develop and for ensuring it meets the needs of each local Place population. This can either be through a number of mechanisms including promoting integration, producing the JSNA and HWBB Strategy for each place and ensuring this is reflected in the System Plan of the ICP and ensuring local accountability for local delivery. Health and Wellbeing Board Chairs could for part of the ICP membership or work with it to ensure it reflects the needs of all SY local population in Barnsley, Rotherham, Doncaster and Sheffield)

Immediate next steps

- Consider key steps to agree the initial ICP chair.
- Consider the role and relationship between HnWBBs and the ICP as summarised above.
- Discuss the approach with wider system partners.
- Arrange for an initial meeting of the delivery group in advance of July 1st (mid-June).
- Local Authorities and ICB to consider draft terms of reference based the paper and Appendix, B to be discussed at the ICP delivery group in June.

Key questions?

- **Do the proposals feel about right for an initial ICP for South Yorkshire?**
- **Do the proposals respond to the challenge of inclusivity and effectiveness?**
- **Has the proposal captured the key purpose and role of the ICP?**
- **Is the proposal for an elected councillor to chair the ICP supported and how might we take that forward?**
- **Do the key immediate next steps cover what we need to do next?**

Will Cleary-Gray, ICB Executive Director of Strategy and Partnerships (designate)
17 May 2022

Appendix, A

Key Considerations	Summary of feedback from meetings of Health and Wellbeing Board Leads from Barnsley, Doncaster, Rotherham and Sheffield
Relationship with HnWBBs	• Local **JSNA** inform HnWBB strategies and local plans and inform and **shape South Yorkshire Health and Care System Plan**. • HnWBBs central role in ensuring System **plan reflects local needs** in each place. • Each Place has an **ICB Place director** key relationship with HnWBB and has ICB team to work with place partners and support development and delivery of local priorities.
Size and make-up of ICP	• General consensus of importance to balance inclusive membership against functioning ICP. • Potential for **wider membership in first year** which could be reviewed as relationships and role is establishes • Potential for : 1. An ICVP **larger forum or assembly** of all partners **meeting 3 or 4 times per year** around developing and setting the Health and Care System Strategy and reviewing progress 2. a **smaller supporting forum** of Local Authorities and the ICB meeting more frequently for example every month initially to establish approach and support the work of the ICP
Chairing of ICP	• No clear consensus - options include: 1. **Elected member** including a Health and Wellbeing Board Chair 2. ICB Chair 3. Other Independent Chair ICB preference for an elected councilor from within the ICB geography
Meeting arrangements and frequency	• See above: • Assembly type forum meeting 3 or 4 times per year around development and review of Health and Care Strategy • Smaller supporting forum to include LA and agreed membership and ICB and agreed membership meeting more frequently • Consensus to have initial arrangements agreed **ahead of July 1st** in development form and proposed **first meeting of the supporting group in mid June**.
Infrastructure and resourcing	• Both ICB and LA would need to consider infrastructure and resourcing for the ICP

Appendix, B

Proposals for South Yorkshire Integrated Care Board

Below is a summary of a proposed way forward to establish initial arrangements for South Yorkshire which build on the work to date and the input of Health and Wellbeing board elected members and lead officers local authority chief executives and ICB chair and chief executive.

Proposals for a South Yorkshire Integrated Care Board from July 2022		
Key features	**Proposed approach**	**Comments**
Responsibility to establish	• Jointly convened by Local Authorities and the NHS. • The ICP is a core element of the statutory arrangements for ICSs which cannot be fully functional without an ICP. • All systems are required to have at least an interim ICP up and running when statutory ICBs commence as planned on July 1st 2022. • An interim ICP comprise a chair and a committee of at least statutory members (the ICB and local authorities), and for there to be agreement on how the committee will be initially resourced.	Local authorities will not have access to any additional funding to support the ICP but should agree with their health counterparts how best to provide the necessary secretariat and other functions vital to the partnership.
General look and feel and key principles	The 5 guiding expectations developed by DHSC, NHSEI and the LGA are: 1. ICPs are a core part of ICSs, driving their direction and priorities. 2. ICPs will be rooted in the needs of people, communities and places. 3. ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences. 4. ICPs will support integrated approaches and subsidiarity. 5. ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights They are also a: • a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population • a forum for NHS leaders and local authorities to come together, as equal partners, with important stakeholders from	

	across the system and community • focus of the ICP will be on building shared purpose and common aspiration across the whole system. • statutorily equal partnership between the NHS and local government to work with and for their partners and communities. • underpinned by the South Yorkshire Health and Care Compact.	
Role and purpose	• enhance relationships between the leaders across the health and care system • facilitating joint action to improve health and care outcomes and experiences across their populations, and influencing the wider determinants of health, including creating healthier environments and inclusive and sustainable economies • developing an integrated care strategy to address the broad health and social care needs of the population within the ICP's area, including determinants of health such as employment, environment, and housing. • enable partners to plan for the future and develop strategies for using available resources creatively in order to address longer-term challenges which cannot be addressed by a single sector or organisation alone	**Some must do's** ICP's integrated care strategy should have regard to the NHS Mandate and any guidance issued by DHSC, and explicitly covers the issue of integration and the use of Section 75 arrangements, including pooled funds. The strategy should also consider a joint workforce plan, including the NHS, local government, social care and VSCE.
Balancing inclusivity and effectiveness and size	Recognised as immediate challenge to overcome. Proposal for initial arrangements: • An ICP with a wider membership inclusive of the full range of statutory and non-statutory partners across the ICS and potentially wider **(Appendix, C)** where this facilitates relationships to take joint action. This would meet approximately time 4-6 times per year to be agreed and linked to development, agreement and review of the Integrated Care Strategy. This would be supported by a delivery group whose membership is drawn from the four Local Authorities and the ICB. Meeting each month initially to support the work of the ICP. The ICP may choose to also convene larger assembly type forums to achieve greater engagement on its work,	Stakeholders would need to be engaged in the ICP work to be 'members' of the ICP. The key is that opportunities for co-production and expert input into ICP strategies are available, this could be through sub-committees or dedicated meetings and events or public meetings, for example.

Chairing	There is no definitive guidance beyond that of good practice. • Chair could be from Local Authority or the ICB, including an elected member. In addition, it could be another independent chair. The ICB has expressed a preference for an elected member from within the SY system. • The proposal is for one of the local authority elected councillors from within the SY geography to chair the ICP. • Given the ICP is to be jointly convened by the ICB and LA. The chair will be jointly agreed.	Expected the person appointed to chair: • be able to build and foster strong relationships in the system • have a collaborative leadership style • be committed to innovation and transformation • have expertise in delivery of health and care outcomes • be able to influence and drive delivery and change
Membership	Proposal for initial arrangements: An ICP with a wide membership inclusive of the full range of statutory and non-statutory partners across the ICS and potentially wider see **(Appendix, C).** this could be in the region of 40 members including the ICB and Local authorities in each of the four places within the ICB geography. The ICP would be supported by a delivery group whose membership is drawn from our four Local Authorities and ICB. Up to eight members from each Local Authority with a minimum to include each Chief Executive and a nominated executive lead to support the work of the ICP and could include addition members from directors of public health, directors of adult social services and directors of children's services. From the NHS up to four members to include the ICB chair and chief executive and an executive lead to support the work of the ICP and could include NHS Trusts, mental health and physical health, primary care, community and the voluntary sector.	**Some must do's** must include as a minimum Local Authorities and the ICB in the ICB area must involve the local Healthwatch organisations whose areas coincide with or fall wholly or partly within its area and the people who live or work in that area"
Meeting arrangements and first meeting	Initial meeting of the delivery group to support planning of the ICP meeting to take place before in mid-June date to be confirmed. • Meetings either remote or face to face to be agreed by the chair. • Meeting venue to be agreed by the Chair and to consider rotation across the four Places	
Secretariat and	• The ICB will provide interim secretariat	

support	support to the ICP for the remainder of 2022/23. • The ICB will also identify a lead executive to work with the ICP on behalf of the ICP. • As part of the transition a review will be undertaken to identify existing resources which align to the work of the ICP and its priorities.	
Relationship with the ICB, Places, wider system	• ICBs and local authorities will be required to have regard to the ICP's strategy when making decisions, commissioning and delivering services. • The ICP should complement place-based working and partnerships, developing relationships.	

Representatives and organisations for ICP wider membership and engagement

We expect the ICP to have a broad membership and engagement with the organisations and communities it serves. However, this membership should be managed appropriately to ensure that the operations of the ICP remain efficient and effective. This illustrative list for ICP membership and engagement should not be viewed as a box-ticking exercise but as a genuine way of ensuring the partnerships include people able to represent and connect with communities and the voluntary sector. We welcome perspectives on whether there are any other voices who should form part of this list. For example:

- voices for children & young people
- patients, service users, & public voices
- voluntary, charity and social enterprise sector
- voices from the Children's Board
- led by and for women's organisations
- Black and minoritised voices
- Healthwatch
- social care providers and workforce
- unpaid carers voices
- disability voices
- mental health providers and service users
- primary care (GPs, dental, eye care, pharmacy)
- NHS Trusts and Foundation Trusts (acute, mental health, community, ambulance)
- community care
- public health voices (e.g., Directors of Public Health)
- local Authority Officers (e.g., Director of Children's Services, Director of Adult Services)
- Acute Care
- housing voices
- Criminal Justice System agencies, including probation services
- offenders health and care voices
- alcohol and addiction services
- homeless services
- social prescribing services
- learning disabilities and autism providers and service users
- businesses
- Local Enterprise Partnerships
- armed forces
- police and crime commissioners
- employment support services (e.g., Jobcentre Plus

HWBB Forward Plan - Public Meetings

Month	Type	Topics	Topic Leads	Ambition	Time	Additional invitees and notes	Chair
8th December 2022	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Oral Health	Greg Fell				
		Health & Wellbeing Outcomes Framework	Sandie Buchan	HI			
		Learning Disabilities/LeDeR update	Heather Burns/Liz Tooke	7			
		Commercial Determinants of Health	Magda Boo/Amanda Pickard	HI			
		Sheffield Health and Care Partnerships	Emma Latimer/Greg Fell				
		Joint Strategic Needs Assessment	Chris Gibbons				
		Violence Reduction Unit	Benn Kemp				
		Infant Mortality	Julia Thompson/Amanda Pickard	1	00:20		
		Health Protection	Ruth Granger		00:10		
		BCF Update	Martin Smith		00:10		
		Forward Plan	Greg Fell		00:05		
					00:55		
30th March 2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Annual Report - look back and impact report					
		BCF Update	Martin Smith		00:10		
		Forward Plan	Greg Fell		00:05		
					00:45		
29th June 2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Health Protection	Ruth Granger		00:10		
		BCF Update	Joe Horobin		00:10		
		Forward Plan	Greg Fell		00:05		
					00:25		
28th September 2023	Public	Healthwatch Update	Judy Robinson		00:10		TBC
		Health Protection	Ruth Granger		00:10		
		BCF Update	Joe Horobin		00:10		
		Forward Plan	Greg Fell		00:05		
					00:35		

Strategy Key			
1	Every child achieves a level of development in their early years for the best start in life	6	Everyone can safely walk or cycle in their local area regardless of age or ability
2	Every child is included in their education and can access their local school	7	Everyone has equitable access to care and support shaped around them
3	Every child and young person has a successful transition to adulthood	8	Everyone has the level of meaningful social contact that they want
4	Everyone has access to a home that supports their health	9	Everyone lives the end of their life with dignity in the place of their choice
5	Everyone has a fulfilling occupation and the resources to support their needs	HI	Overall Health Inequalities Goal

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